BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE FUNCTION OF THE INTAKE SOCIAL WORKER IN A MENTAL HOSPITAL

A Thesis

Submitted by

Jane Bosworth Eddy

(B. A., Smith College, 1946)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1948

ACKNOWLEDGMENT

The writer wishes to acknowledge the great amount of assistance given by Miss Anne P. Ogilby, present intake social worker at the Boston Psychopathic Hospital, who did much to help the writer achieve a more complete study of the function of her position.

TABLE OF CONTENTS

CHAPTER		PAGE
I	INTRODUCTION	1
	Purpose	2
	Background of Study	3
	Method and Scope of Study	9
II	AN ORIENTATION TO PSYCHIATRIC SOCIAL WORK IN MENTAL HOSPITALS	11
III	THE ROLE OF THE SOCIAL WORKER WITH THE PATIENT	21
	At Admission	25
	Continued Contact	29
	Discharge	33
IV	THE ROLE OF THE SOCIAL WORKER WITH THE RELATIVES	41
	Contact at Admission	41
	Continued Contact	51
	Purpose of Continued Contact	52
	Group Meetings with the Relatives	56
V	THE ROLE OF THE SOCIAL WORKER WITH THE DOCTOR AND IN FOLLOW-UP	62
	Doctor and Social Worker	62
	Follow-up	70
VI	SUMMARY AND CONCLUSIONS	75
	Summary	75
	Conclusions	82
VII	BIBLIOGRAPHY	85
VIII	APPENDIX	88

LIST OF TABLES

TABLE		PAGE
I	DISTRIBUTION OF DIAGNOSTIC CATEGORIES	22
II	SOURCES OF REFERRAL TO THE HOSPITAL	22
III	TYPES OF ACTIVITY ON PART OF SOCIAL WORKER WITH THE PATIENT	32
IV	REASONS FOR INACTIVITY ON PART OF WORKER AT POINT OF DISCHARGE	34
V	AREAS OF ACTIVITY ON PART OF WORKER AT POINT OF DISCHARGE	34
VI	DEGREE OF RELATIONSHIP OF THE WORKER WITH THE PATIENT	36
VII	UNIQUE PURPOSES OF CONTINUED CONTACT WITH THE RELATIVES	53
VIII	REASONS FOR THE WORKER'S CONTACT WITH THE DOCTOR REGARDING THE PATIENT	66
IX	REASONS FOR NO FOLLOW-UP OF THE PATIENT BY THE WORKER	71

CHAPTER I

INTRODUCTION

"A routine social examination for all admissions was our ultimate aim."

E. E. Southard and Mary C. Jarrett.[1]

So said the psychiatrist, Dr. Elmer Southard, and the psychiatric social worker, Miss Mary Jarrett, when speaking of one of the aims of the social service department as it was established at Boston Psychopathic Hospital 1913. The writer initiates her study with this sentence, because it seems particularly pertinent in its relation to the present role of the intake social worker. Since the object of this study is the function of this worker, the degree to which her role fulfills or exceeds this aim would seem to be important.

Thirty-five years have passed since this aim was expressed, and as there were at that time many discussions, reports, and studies on the potentialities involved around the role of the psychiatric social worker in a mental hospital, so today those studies continue with evaluations from the experience of the thirty-five years. Doctors, students, and the social workers have spent much time analyzing this area of service in a mental hospital. They have approached the subject from many directions--the value to the doctor,[2] the patient or relative,[3] the need of social

---

1. E. E. Southard and Mary C. Jarrett, The Kingdom of Evils, p. 525.

2. Group for the Advancement of Psychiatry, Study of the Role of the Social Worker in a Mental Hospital.

3. M. G. Muller, "Case Work Aid to Patient and Family Following Hospitalization for Mental Illness," The Family, 22:251-253, December, 1941.

histories in this psychiatric setting,[4] or service in this setting in terms of the entire field of psychiatric social work.[5] The difference in approach over the years seems to lie in the present acceptance and recognition of the need of the social worker in a mental hospital, but with the focus now on what areas of function should be included within that role. For example, discussions of recent years have centered on the areas of service designated to the social worker within the hospital, rather than as in the past, controversy over whether or not a social service department should exist.[6]

Purpose of the Study

The purpose of this study is to analyze the role of the "Intake Social Worker" in Boston Psychopathic Hospital today. The value of the presence of social service, in general, within the hospital will be assumed as accepted, and thus the focus will be centered on an attempt only to define and describe the areas of service covered by this particular worker.

There have been two methods of procedure in regard to social service in a mental hospital. On the one hand, there is the policy whereby the doctor is the judge of whether or not at the point of admission there

---

4. Irma Landquist, The Use of the Psychiatric History Interview. Boston University, 1947.

5. Lois French, Psychiatric Social Work, Chapter IV.

6. M. G. Muller, "Case Work Aid to Patient and Family Following Hospitalization for Mental Illness", The Family, 22:251-253, December 1941.

is a social problem, and upon his decision a referral is made to the social service department. The other method is planned to have the social worker present at the time of admission to study the social situation and give a report to the staff regarding the presence or absence of a social problem.

The former method has been the one currently used; the latter continues to be studied with its many ramifications. For two years an intake social worker has been employed at Boston Psychopathic Hospital, and at the time of the establishment of this position, it was of an experimental nature. It is around this worker's role that the attention of this study will center--in its relation to the patient, doctor, relatives, and community. Such questions as how these various groups of people connected with the hospital setting use this worker, with what group she is most active and the duration of her contact with them will all be important. In summary, what place does she occupy in the hospital efficiency, and in the care of the patient?

Background of the Study

In order for the reader to better understand the area of study of this paper, it would be helpful to trace briefly the evolution of social service up to the establishment of this present position of "intake social worker". The Boston Psychopathic Hospital was formally opened as a Department of the Boston State Hospital, June 24, 1912. The purposes of the Hospital as stated by Dr. May were:

> The Psychopathic Hospital should receive all classes of mental patients for first care, examination and observation, and provide

> short, intensive, treatment of incipient, acute and curable insanity.[7]

The social service department was established in 1913, one year after the opening of the hospital. The following indicates the beginning of this department:

> The Director of the Psychopathic Hospital saw that social work, particularly in hospitals, had already developed far enough to have produced a wealth of experience that could be applied in a new social service department. He appointed a director of the department, or "chief of social service," whom he instructed to develop and organize the social work of the institution in close relation to the Out-Patient Department.[8]

This department recognized the necessity of history-taking as requested by the doctor for many cases. Although the ultimate aim (as stated in the introduction) was routine social examination at admission, referrals were left to the doctors, because of the inadequacy of staff to accomplish the aim. Social service included in its function both social diagnosis and social treatment, given on an intensive or slight service basis. In the former, social service "took responsibility for a full inquiry into the social condition of the patient and his family and for a plan of treatment, to secure their social adjustment."[9] In the latter, "assistance was given without inquiry beyond the apparent facts, or responsibility beyond the immediate service."[10] At this time, social service

---

7. James V. May, M. D., Mental Diseases, (Boston: R. G. Badger, 1922), p. 108.

8. L. V. Briggs, History of Boston Psychopathic Hospital, p. 173.

9. Ibid., p. 177.

10. Ibid., p. 177.

played an important part in facilitating early discharges, in after-care and in investigating previous histories of patients.[11]

In 1920 the Boston Psychopathic Hospital became a separate institution under the Department of Mental Diseases, with its own superintendent. It continued to give its previous services, and as a separate institution was a leader as a teaching, diagnostic, research and treatment hospital. Throughout these years a close relationship of the medical and social work staff was fostered by the director in every way. For a number of years, beginning in June, 1913, an Annual Conference on the Medical and Social Work of the Psychopathic Hospital was held,[12] and in addition, social workers were expected to attend the daily medical staff meetings, so that the social work as well as the medical staffs could be guided in education. Social service was organized to assist in the medical work of studying and treating mental disease. Dr. Southard said of Social Service at the Boston Psychopathic Hospital:

> We claim no novelty or originality for the social work of the Psychopathic Hospital, but rather we would claim to have created the part that the social worker is to play in the mental hygiene movement and to give it a name--psychiatric social work.[13]

Social Service has always assumed an active role in both the Out-Patient Department and in the Hospital, but over the thirty-five years since its creation, varying degrees of specialization, division and

---

11. Anne Ogilby, Environmental Factors and Mental Disturbances, Simmons College, 1946, p. 6.

12. L. V. Briggs, History of Boston Psychopathic Hospital, p. 174.

13. Ibid., p. 182.

separation of function have been apparent.[14] These changes have come about in an attempt to achieve the type of service of most benefit to the patient and his relatives.

Specialization has existed from the beginning. For instance, social service with the neurosyphilitic patients was established as a separate unit when the social service department was organized, a special worker being in charge in that department. The early records show that certain workers were assigned specific jobs in the areas of unemployment, and special investigations, as well as follow-up in the Out-Patient clinic. An unsuccessful attempt was made to have a worker screen all admissions. It is felt that the cause for failure of this limited attempt may have been due to too much concentration on getting a social history.

The degree and type of specialization of function varied according to the amount of integration that existed between the services of the doctor and social worker. A "historian" was responsible at one time for the history-taking on patients admitted into the Hospital, but as the focus changed it was felt that more might be accomplished if this information were obtained by the doctor. Still another period saw social service getting much of the history material.

The desire for closer cooperation between the social worker and the doctor brought about the inclusion of members of the Social Service Department at ward staff meetings where it was felt that both could mutually

---

14. Annual Reports of Boston Psychopathic Hospital, 1913-1946, Section on Social Service.

benefit. For example, a worker was assigned to each service--male and female--to attend weekly staff meetings. The importance of the assignment of these special workers was that:

> whenever the social worker observed a problem which she felt the social service department could care for, she outlined her point of view to the doctors, who were thus enabled to learn how the Department functions to bring about better adjustment of the patient either to his own difficulty or to his family or the latter to him. She helped the physicians see that although certain patients showed much improvement during hospitalization residence, there was unfortunately no place in the community for them which would not be filled with stress and which might bring about a return to the hospital.[15]

However, this approach gradually changed as a greater amount of initiative was taken by the doctor in contacting the social service directly regarding social problems.

Almost from the inception of social service in the hospital, investigations were obtained on all court cases, and eventually, because of the large number of social investigations necessary, the court cases were permanently assigned to one worker whose function since that time has been to investigate each of these admissions. Following this investigation, she consults with the physician deciding cooperatively with him on those cases necessitating further analysis.

Dr. Harry Solomon, present director of the hospital, has done much to increase the interrelationship of hospital departments and, with the Director of Social Service, has aimed at having her department more active with the patient and relatives from the time of hospitalization. He saw

---

15. Annual Report of Boston Psychopathic Hospital, 1944, Section on Social Service.

as particularly valuable the availability at all times of a worker for the patients and relatives from admission onward, and in 1946 there was added a third area of specialized service in addition to the court and neuro-syphilitic units. A worker, then a student, was assigned the function of interviewing every informant and patient, exclusive of court and neuro-syphilitic cases, at the point of admission. The purpose as stated by the worker was:

> not to take an intake history, but rather to see if any social problem or problems exist now, or have existed, which might have some relation to the patient's present mental condition, and be of help to the doctor in understanding the patient.[16]

The plan of intake has become an integral part of the hospital's total plan of service to the patient. The student has remained and carried on into a regular program the experiment she had undertaken. In the Annual Report of 1946, the Director of Social Service states, "She made no attempt to take a social, medical history, but she did inquire about the social stresses caused by the patient's admission to the hospital . . . She offered them assistance." It was felt by the Director that by giving the relatives some concrete help around the financial situation, a discussion of which she included in her function, the relatives could see the understanding and tolerance of the worker, and thereby be anxious to come for help again. It was felt that security and help could be gained by the patients and relatives by knowing that such a worker was available for their use.

---

16. Anne Ogilby, Environmental Factors and Mental Disturbances, Simmons College, 1946, p. 6.

Method and Scope of Study

In order to study the present role of this worker within the hospital, a sampling of cases was made, taking the admissions of the month of September, 1947. This month was chosen mainly because it was recent, and at the same time most of these patients would have been discharged by the time of the completion of this study. One hundred and five patients were admitted to Boston Psychopathic Hospital during this month of September. Of this group forty-three cases came from the court, and were consequently handled by the worker in charge of these admissions and twelve were taken by neurosyphilitic service. The remaining fifty admissions fell within the area of function of the intake social worker, and these were the cases thus chosen to be studied.

Each case record was read in order to get a background into the patient's illness, and the notebook of the worker consulted for pertinent social data. However, because of the limitation of recording, much of the information regarding the worker's service to these patients was obtained through reviewing with the worker personally each case admitted during that month, and her contact with patient, doctor, relative and outside sources. (See Schedule in Appendix.) Because of this, it was felt that some details would not be revealed, and the material of necessity assumed a somewhat summarized form, in contrast to the day to day entry of a record form.

As these cases were studied, another limitation was discovered. In September, a new group of students entered the department for training during the winter. Because of their need for orientation during this

first month, and their greater demand of their supervisor's time, fewer referrals of hospital admissions were made to either students or regular workers by the intake worker. Consequently, more of the September cases were carried and known in detail by the intake worker. Because of this, the area of referrals was not considered representative and so not included in the study.

Observation of this worker in her role with current cases gave added information to complete details of this study as will be revealed later in the discussion of the worker's role in group meetings. Other elements of function were described by the worker to the writer for the purpose of the study.

CHAPTER II

ORIENTATION TO PSYCHIATRIC SOCIAL WORK IN MENTAL HOSPITALS

In the first chapter it was shown briefly how social service was established and has developed in Boston Psychopathic Hospital over thirty-five years. This department of the hospital from the beginning has been a training center for programs in other hospitals, as stated and quoted by Dr. Solomon in a report to the hospital.

The study of the role of the social worker and the place of social service has been studied from many points of view: through individual description of the departments of particular state hospitals, through historical summaries, and through controversial discussions of distinct areas of service. These studies, general or specific, have revealed much material to guide workers of the future.

Beyond these efforts, a study was made by all the state hospitals of their beliefs of what part social service should play in the various phases of the patient's hospitalization.[1] A summary was made of these findings, and proved interesting in the light of a future goal for social service. This program is not carried out in many hospitals, but would be considered essential as an aim. At intake, the worker can be helpful in screening admissions, interpreting hospital facilities and program to both patient and relatives; in some instances offering services to the family with problems relative to leaving the patient in the hospital, helping to reduce

---

1. Group for the Advancement of Psychiatry, Study of the Role of a Social Worker in a Mental Hospital, pp. 8-14.

anxiety around continued treatment for the patient, and securing their cooperation. At the reception of the patient the work of the social worker should be integrated with that of the admitting physician, explaining to the patient what the conditions of the hospital are, in some instances cooperating in selection of patients, and orienting the patient to the next steps in treatment. These functions are qualified by the statement that they must be related to the specific hospital and integrated with other professional categories of personnel.

Interpretation of special treatment programs, it was agreed, should be left to the doctor, but the social worker could play a part in continued treatment. She was recognized as the most effective person for maintaining a continuous contact between the patient and his family, and as a liaison with the community. Her relationship with the family would enable her to help around areas of emotional strain being revealed, and in evaluating the home situation to which the patient would return. Her place in preparation of the family for the return of the patient to his home should be balanced with her knowledge of the progress of the patient in his treatment.

The social worker's knowledge of the family and community resources should enable her to help in the formulation of discharge plans and in exercising supervision of the patient in his readjustment to the community. This was considered a large area of service. The social history was revealed as essential for differential diagnosis and continued treatment, but it was focused on the fact of its being a fluid body of information, and one gathered progressively over the total period of the worker's relations

with the family and the patient.

The above study does not describe what is, but what is believed should be involved in social service in a mental hospital. Many individual studies[2] have revealed also what role the social worker should play, emphasizing her role with the doctor, patient, or relative, or the value of the social history, or a family care program. In studying these various reports, it is found that the emphasis has changed, and that elements proposed in earlier years, are now in effect. For example, as early as 1933, it was stated how important commitment is to both patient and relative and that interpretation of hospital procedures alone during the intake period would help them be more cooperative and understanding.[3] The following statement of the same period emphasizes this: "Social service participation is too rarely considered a part of treatment until the patient is ready to leave the hospital."[4]

Early emphasis was on understanding the effect of the stigma of the mental hospital upon both hospital and patient, and that help in this area was particularly valuable, and this stigma still has need to be stressed.

---

2. R. R. White, "The Social Services in the State Hospitals of Illinois," Mental Hygiene, 27:554-573, October, 1943.

3. Hester Crutcher, A Guide for Developing Psychiatric Social Work in State Hospitals, p. 11.

4. Committee on Psychiatric Social Work in Mental Hospitals, Essentials of Psychiatric Social Service Technique in Mental Hospitals, and Mental Hygiene Clinics Attached to Mental Hospitals, p. 1.

> Because of the archaic stigma which still exists to some extent regarding mental illness, they hesitate to discuss the problem, or they grope blindly for help in understanding the malady. They have fears for the mental health of other members of the family, about which they may need reassurance and certain attitudes of their own which they need help in handling.[5]

This has been one of the strong arguments up to the present time for the need of a worker at admission, and in interpretation of mental illness to the community.

Much of the social worker's function in the hospital has been described around the social history. Customarily, the doctor referred a case to social service either for intensive or short-service care. In both areas, a history, whether complete or brief, was essential, and this was considered one of the main areas of service of the social worker. By obtaining a social history the worker was able to have contact with the community, the patient and the relatives.

> Social study of the environment is recognized as a necessity; a chronological summary is evident; a social analysis is desirable where intensive psychiatric social service treatment is being done; the interviewee's definition of the problem involved and his solution of the same is taken under consideration.[6]

In many instances it was an end in itself, and became a routine procedure. It was seen, and is still, as a means whereby the social worker can establish a contact with the patient's family, which can be of great assistance

---

5. _____, "The Function of the Psychiatric Social Worker in a Mental Hospital," Newsletter, 12:8, Summer, 1942.

6. Committee on Psychiatric Social Work in Mental Hospitals, Essentials of Psychiatric Social Service Technique in a Mental Hospital and Mental Hygiene Clinics Attached to Mental Hospitals, p. 1.

in the patient's return to the community. Doctors in many hospitals take the main part of the history from the patient's relatives, supplemented, when deemed necessary, by the material secured by the social worker from interested social agencies and other sources.

However, history taking has undergone much scrutiny in recent years, with the realization that the emotional components of guilt, anxiety and fear often color the facts given by the relatives, and that many times case work help can begin with great value at this point. Both patients and relatives have assumed more of an individuality. The fact that the trained psychiatric social worker can pick up and handle many of the emotional tones, has given this element in the history taking as important a place in the eyes of the social worker as the facts themselves. The facts are no more important than the emotional tones surrounding them.

In addition to gaining the facts for diagnosis and treatment, the social worker at first was seen as a help in convalescent, family and "parole" care. Many times this involved contact with the patient and his relatives only at the point of discharge, and often involved work and follow-up mainly out of the hospital. The worker acted as aid to the psychiatrist working under his direction and at his request. This program of service of the social worker has gradually changed, as is obvious in the object of study of this thesis. Although the social worker still performs some of the above functions the scope of her role has increased. Miss Gartland has made a revealing summary of the gradual changes that have come about:

1. The psychiatrists who first used social workers sought data about the social environment and the behavior of their patients as evidence on which to have diagnosis and treatment plans.

2. The social worker was seen as the one to create for the patient who had been discharged from the hospital, an environment in which emotional strain would be at a minimum.

3. The social worker was seen as the psychiatrist's aid, and the idea was that she should work under his direction. The desires of the patient and of those who live with him were taken into account chiefly because it was necessary to secure their cooperation.

4. The focus changed, however. While it was still concerned about the social problems related to the illness, its emphasis shifted from gathering facts about these problems for study only, and from planning and doing for the patient and his relatives, to a dynamic process based upon a belief that even psychiatric individuals, especially those ready to leave the hospital, can best be helped by working with them rather than for them.

5. The development has influenced both the information gathering and the social treatment aspects of psychiatric social work. Relatives and patients who are sufficiently in touch with reality are seen for the purpose of helping them discuss the social difficulties they encounter in relation to the illness in the present, and of enabling them to deal with those difficulties before they become insurmountable obstacles in the path of the patient's return to healthful social functioning within the limits of his capacities.[7]

For many years it has been emphasized that social service should be regarded as an integral part of the whole approach to the solution of the patient's difficulties.[8] This has been recognized only in limited degrees by the administration of various hospitals in past years and this is an area where change can be noted and development in the process. "A social service department cannot function independently and as a separate entity.

---

7. Ruth Gartland, "The Psychiatric Social Worker in a Mental Hospital", Mental Hygiene 31:287-288, April, 1947.

8. Hester Crutcher, A Guide for Developing Psychiatric Social Work In State Hospitals, p. 9.

It must relate itself to the hospital in its entirety."[9] This emphasis is related to the belief that the social worker is a part of the hospital team, with the doctor, and, as such, has an important, defined role.

In 1940, it is stated that "in some hospitals the social worker routinely assisted in social investigations for each patient", and the role of the social worker at intake is described as "the first step in the important process of social treatment, which later is to involve explanation to the family, further understanding of the family situation, preparation for the return of the patient and follow-up after discharge."[10] These positions vary from screening at admission with no further contact until referral from the doctor, to continuous contact and presence on ward rounds with the doctors. All of these programs are based, however, on the fact that planning should start "when the patient comes to the hospital and should develop in keeping with the patient's progress or response to hospital treatment."[11]

More study has been made of the needs of relatives from the point of admission than those of the patient. However, emphasis has been placed on the feelings of the patient who considers himself trapped in the hospital, who receives no explanation of what the hospital is like, and who is automatically shut off from his previous life experience without any element of

---

9. R. R. White, "The Social Services in the State Hospitals of Illinois," Mental Hygiene 27:559, October, 1943.

10. Lois French, Psychiatric Social Work, p. 127.

11. _____, "The Function of the Psychiatric Social Worker in a Mental Hospital," Newsletter, 12:8, Summer, 1942.

contact with the community except through the doctor. The statement has been made that "feeling needed is probably the greatest dynamic to recovery that the state hospital has to offer." By this is meant that patients often feel unwanted by unfeeling relatives or relatives upset over the stigma attached to a mental hospital, and that both doctor and social worker can give a great deal to a patient through understanding of him as a person, accepting both the well and sick in him.

Several studies have been done regarding the relatives of the mental patient. Three Smith Studies were made regarding the possible role of the social worker with the relatives.[12] One of these studies approached the situation to study how much need there was for case work with the relatives of psychotic patients and studied it with the following elements in mind: attitudes toward hospitalization, opinions regarding the cause of the psychosis, opinions regarding the social, psychiatric history, attitudes toward the sick patient, and the handling of the psychotic behavior. Most of the group of relatives showed reactions which would probably interfere with sympathetic relationship between patients and relatives.[13]

The result of the study of intake interviews with a group of relatives revealed the following, seeing the interviews as:

---

12. Joan R. Brown, "The Need for Case Work with Relatives of Mental Hospital Patients," Smith College Studies, Vol. XIII, No. 2.
Helen Darraugh, "The Role of Social Service with the Families of Mental Hospital Patients," Smith College Studies, Vol. XIII, No. 2.
Esther Goodale, "Intake Interviews with Relatives of Psychotic Patients," Smith College Studies, Vol. XV, No. 1.

13. Joan R. Brown, "The Need for Case Work with Relatives of Mental Hospital Patients," Smith College Studies, 13:187, December, 1942.

1. An outlet for the relatives' emotional tensions.

2. An opportunity for the psychiatric social worker to give an explanation of:
   a. the psychiatric social history, its content, why it is taken, and how it is used to the benefit of the patient.
   b. the social service department in general, its area of function in the hospital, and how the patient and relatives can use its services.
   c. the plan for a definite appointment time for taking the history, the probable duration of the appointment, and the worker's name.
   d. routine hospital services.
   e. the court hearing and summons, if any question about them arose.

3. An opportunity for the case worker and relatives to decide which relative or relatives should be the informants for the history.

4. An opportunity for the relatives to ask questions about the hospital and for them to talk to someone to whom they could comfortably express their own doubts and fears, if any, about the hospital.[14]

These conclusions seem to reveal the basis of arguments for an interview with relatives at the point of admission, and show dynamic elements present in a situation which is emotionally charged.

The social worker is aware that the relatives need help from the very beginning in understanding the mental patient. Miss Edith Stern gives the relatives a guide in her book about the handling of the mental patient in the hospital.[15] She tries in print to give the relatives the reassurance and tangible aids and information so necessary for relatives, much the same information that the social worker explains in an intake interview.

---

14. Esther Goodale, "Intake Interviews with Relatives of Psychotic Patients," Smith College Studies, 15:49-50, September, 1944.

15. Edith Stern, Mental Illness: A Guide for the Family.

Thus, there is evident a realization of the emotional elements surrounding admission of a patient to a mental hospital. The handling of these emotional elements through the use of social service from the beginning of the patient's hospitalization remains still in the realm of what should be rather than what is. In fact, both the Director of Social Service and the Intake Social Worker at Boston Psychopathic Hospital feel that the position of Intake Social Worker as it has existed during the past two years at Boston Psychopathic Hospital is unique in its coverage of all admissions (both the patient and his relatives). Therefore, the study of the function of this worker is a particularly interesting one.

CHAPTER III

THE ROLE OF THE SOCIAL WORKER WITH THE PATIENT

The patient is the center of focus in the mental hospital. The social worker, like the doctor, aims for the "restoration of the capacity for normal living, or/and the provision for the greatest possible comfort."[1] Dr. Southard, when Director of Boston Psychopathic Hospital, said, "She [the social worker] must identify herself with him [the patient], directing him from his own point of view, giving him the counsel of 'a friend', not merely the advice of 'an authority'."[2] Throughout her contact with the patient, it is important for the social worker to remember what the difficulty (or diagnosis) is, how long the patient has been in the hospital, and whether he has been previously hospitalized.

Of the fifty admissions coming within the service of the intake social worker during the month of September, the age range of the patients was from seventeen to sixty-two years, and the duration of hospitalization from four days to over four months, the majority of the patients remaining in the hospital no longer than a month. The following table gives the distribution of diagnosis:

---

1. E. E. Southard and Mary C. Jarrett, The Kingdom of Evils, p. 524.
2. Ibid., p. 547.

TABLE I

DISTRIBUTION OF DIAGNOSTIC CATEGORIES

Diagnosis	Number of Cases
Dementia praecox	27
Involutional psychosis	7
Psychoneurosis	5
Manic depressive psychosis	3
Alcoholic psychosis	3
Undiagnosed psychosis	2
Alcoholism	2
Psychosis with mental deficiency	1
Total	50

Of this group, twenty-two patients came into the hospital for a lobotomy operation. Because of this large group of cases and the fact that this realm of treatment is new, it will be essential to note any uniform type of service needed from the social worker.

These patients were referred to the hospital from the following sources: the Out-patient Department of Boston Psychopathic Hospital, another hospital, by a friend, the family, or a doctor.

TABLE II

SOURCES OF REFERRAL TO THE HOSPITAL

Source	Number of Cases		
	Directly into Hospital	Via Waiting List	Total
Another hospital	26	0	26
Out-patient department	5	4	9
Doctor	4	4	8
Family	4	0	4
Friend	2	1	5
Total	41	9	50

These cases from the Out-patient Department are referred by doctors attached to the hospital, and consequently the worker may be informed by the doctor of the known social aspects prior to the patient's admission. The predominance of cases coming from another hospital can be explained by the twenty-two lobotomy patients, most of whom had been hospitalized for some time prior to admission to Boston Psychopathic Hospital. Of the group of fifty patients, nine came via the waiting list. This number is atypical, the intake worker states, as the monthly average is approximately twenty patients.

Included within her administrative functions, the waiting list is maintained by the intake social worker. When a patient is referred for hospitalization and a bed is not available, she places the patient's name on the waiting list, explaining the procedure to the patient, doctor or relative as the case may be. When admission can be made, it is on the initiative of the social worker that the patient is contacted. This function has obvious administrative value, but it would seem to go beyond this. Whether the social worker at the time of entering the patient's name on the waiting list, has contact with the patient himself, or someone close to him, the opportunity has already presented itself for the worker to show her desire to understand and help the patient. For example, Mrs. G. was quite upset and anxious throughout the waiting period and called the worker twice, while Mr. S. used the worker for a different reason, mostly to ascertain what he should bring to the hospital in the way of clothes and what plans would have to be made.

Knowledge of a patient's previous hospitalization is also important for the intake social worker, because it is an aid in evaluating the amount of interpretation regarding hospital procedure that may be necessary at the point of admission, both for patient and relatives. In thirty-five of the cases, there had been no previous admissions to Boston Psychopathic Hospital (although in some instances there had been to other hospitals). Eight of the patients had been admitted previous to September 1946 before the social service department had taken on the function of being present at each admission. In seven cases, the worker had been active at the patient's previous admissions. In three of these seven cases, the patient had also had a previous admission to Boston Psychopathic Hospital before September 1946. No interpretation to the patient was necessary, but an interval picture was obtained. In all seven cases where the patient had been admitted to Boston Psychopathic Hospital since September 1946, the patient and relatives were aware of the worker's function because of their previous hospital experience, and it seems that the mere presence of a familiar person at admission would have considerable value in the security it might give.

Patients can enter the hospital today under any one of the following legal categories: 1. Section 79 for temporary care (not to exceed ten days); 2. Section 100, more commonly known as court cases; 3. Section 77 for thirty-five days observation; 4. Section 51, which allows for an indefinite period of observation and treatment; 5. voluntary patients. Patients admitted during September 1947 were admitted under all the categories (although court cases, Section 100, are not discussed in this study).

It is important to note the fact that in eighteen cases there was a change of status made during the patient's hospitalization. In fourteen of the eighteen cases it was from Section 79 to Regular Commitment under Section 51. In the other four cases it was the following: 1. Section 79 to Section 77; 2. Section 79 to Section 77 to Voluntary status; 3. Section 79 to Section 77 to Section 51; 4. Section 79 to Voluntary status. The importance of change of status during hospitalization lies not so much in relation to the patient as to the relatives. However, the realization that hospitalization is no longer on a temporary basis (if commitment is the result), but in terms of a longer period or indefinite commitment can be very threatening and anxiety producing for the patient, giving rise to fears that he may never be able to leave the hospital.

Role at Admission

The legal status of the patient at admission is one of the first things that the worker learns, because she is present in the admitting office when the patient arrives. Of the fifty cases studied, the worker was present at the admission of all but four, these four being seen on the ward by the worker within two days. In sixteen cases the worker, besides being present at admission, took the face sheet information usually obtained by the doctor, the doctor completing the admitting process from this point. Although the value of the presence of the social worker at admission, was not ascertained when the position of "intake social worker" was initiated, it has assumed an important part in the worker's relationship with the patient (and relatives). It correlates highly with the original

idea of Dr. Harry Solomon.[3] Nor was it at first seen as her role to take the face sheet for the doctor. May it be clarified at this point, however, that although the worker may make out the face sheet, she cannot officially admit the patient. This is the doctor's responsibility.

The purpose for the presence of the worker at admission is first to become acquainted with the patient (and relative) to assure where it is necessary and to "screen" the situation for social problems. This purpose was designated as her original function two years ago and stated as such by the worker. For clarification, this purpose can be divided into two parts. First of all, the worker is present to notice and pick up any social problem that may be present at that moment or any other information which would enable the doctor and social service to give the patient the most helpful and inclusive treatment. However, it goes further than this in what it does for the patient. The worker is there to give any explanation which may be necessary. It may consist of anything from just being friendly, to helping the patient with some particular area that needs service immediately. For example, the worker may only give the patient a package of cigarettes because his were forgotten. On the other hand, her help may involve reassurance that she will help his wife regarding financial aid. In twenty-one cases, the worker was present but not active in the realm of verbal explanation, interpretation or reassurance because the patient was too sick and thus inaccessible, explanation being impossible. However, the worker became familiar with the patient and his condition in

---

3. See page 7.

preparation for later service to him. Her passivity in these cases did not mean lack of service, because it has been found that when the patient's mental condition has improved, he remembers that there was an understanding woman present in the room when he was admitted. Because of this, considerable emphasis has come to be placed on the value of the worker as an attractive female figure in the patient's environment in the admitting office. The emotional component alone is important.

Of the remaining twenty-nine cases, the worker was verbally active in all but four. In those four, the patients were already acquainted with the hospital and presence and use of the social worker. By "verbally active" is meant that a rather routine pattern was followed in most of the cases of getting acquainted with the patient, explaining the procedure of the hospital, and giving an interpretation of the observation wards and the patient's eventual transfer to a convalescent ward. In addition, the patient is told that the worker will visit him within a few days. This gives him something to grasp as the relatives leave him in this new setting. It is a definite means of helping the patient as he makes his entrance, of reassuring him, of giving him a link with his relatives, even though they have to leave him. When no social problems present themselves at admission,

> this does not mean that the interview had little value in terms of the treatment of the patient. Through an explanation of the function of the social worker, the patient will feel far less isolated and the possibility of contact with the outside world, through the social worker, may help him to be more accepting of hospital restrictions than he has previously been. Such an attitude makes him receptive of the hospital program for his treatment.[4]

---

4. _____, "The Function of the Psychiatric Social Worker in a Mental Hospital," Newsletter, 12:7, Summer, 1942.

Admission to a mental hospital is traumatic for a patient even today. Along with the fear and anxiety that such an experience brings, there are practical problems involved which can further increase the anxiety. The case of Mr. N. is a good example, presenting an immediate problem which made hospitalization more difficult for him.

> Mr. N. came into the hospital under Section 79 and was hospitalized for a period of two months, necessitating a change in legal status from Section 79 to 51 RC. He was referred to Boston Psychopathic Hospital from a medical hospital because he was depressed and agitated, and afraid to go home. He and his wife lived alone in a single home, their children grown up and married, and unable to help financially. Mr. N. was the wage earner in the household, an office manager by employment. The intake worker was present at admission, for the usual screening process, and the patient was accessible, resisting entrance to the hospital. Realizing he was the wage earner, he was worried about leaving his wife, who would be unable to get along financially. Worker realized that here was a social problem to be faced not only with his wife after the patient went to the ward, but something around which the patient needed reassurance immediately. Worker explained she would be able to help his wife obtain maintenance, and showed briefly how this was sometimes arranged. Beyond this immediate problem the patient was anxious about being so definitely separated from his wife by hospital commitment, and the worker explained the hospital and ward to him, saying she would be up to see him within a few days to clarify any questions he might have. Worker saw the patient on a weekly cooperative basis after this, where she could tell him what financial arrangements had been made, to reaffirm his wife's statements that she was able to manage adequately, and share with him her contacts with his wife.

In this case the worker was able to help a patient enter the hospital without undue concern over the maintenance of his home. With explanation and reassurance, the patient became more cooperative, but at the same time remained one who needed help throughout his stay. The worker from the beginning became the link for this man with the environment he was leaving, and made the break less final. Here too the admission contact was important in relation to the worker's role with the wife, because the worker

was able to see from the patient an immediate area of help for this relative for whom hospitalization was also a traumatic experience.

Continued Contact

From admission, the social worker knows each patient at least by name. This means that she can recognize these patients on the wards, speak to them, and that they in turn know her and can call on her when necessary.

Because of the unscheduled nature of many of the interviews of the worker with the patients, due to the fact that she is on the wards daily, it is impossible to give exact statistics regarding the number of contacts. Consequently, in this study, scheduled interviews only were recorded. In twenty-two of the cases, the patient was not interviewed on a case work basis regularly throughout his hospitalization. Of these cases, seven were too sick to use service, three needed only one interview regarding discharge (other contacts being informal), two were being followed by another worker and eight were only on a friendly basis, or in order to give reports to the relatives. The remaining two of the twenty-two had no social problems involved at all, and any contact was just a friendly one. For example:

> Mrs. B. was transferred to Boston Psychopathic Hospital for a lobotomy operation from a hospital in another part of the state. Before her initial hospitalization, the patient lived with her husband and son. Both her parents and her husband were interested, but her husband was out of the country, leaving the responsibility with the patient's elderly mother. The worker was present at admission, but the patient was inaccessible, and was not seen again by the worker until postoperatively. Patient's mother told worker that the husband was anxious to make convalescent home plans if this were possible. Since the patient did not improve sufficiently, such plans were not discussed further.

> Postoperatively, the worker saw the patient briefly about four times, in order to give reports to the husband and the patient's elderly mother, and to find out periodically if anything was wanted by the patient. Her elderly mother was unable to visit frequently, leaving the patient quite alone.

Here case work is done by the social worker through support and helpfulness, although no major problem presents itself. With only infrequent visits by those close to her, the feeling of being forgotten was more acute for her than for most hospital patients. This loneliness could naturally affect the patient's cooperation during hospitalization and the worker tried to ease this by her visits, forestalling by warmth and understanding a need which the patient had not yet expressed.

The majority of lobotomy patients were inaccessible prior to operation and generally the worker did not attempt any formal interview until postoperatively. At this time, if the patient were sufficiently improved and any social problems presented themselves, she became active. Any contacts prior to operation were of a friendly nature and in preparation for planning, if the patient were well enough postoperatively.

Among the twenty-eight cases in which the worker saw the patient on a regular interview basis (supplemented by unscheduled contacts), the majority were seen weekly. Many of the interviews, however, were of less than an hour's duration, due to restriction of time on the part of the worker. In three cases, interviews were twice a week, and in two others almost every day.

Who instigated these interviews? Of the group of fifty cases, eight had relatively little contact. In twenty-three cases it was the worker's initiative consistently throughout in the relationship. Three reasons

must be considered for this: first, the patient can not come to the worker because the doors to the wards are locked and the patient feels hesitant to ask the nurse to call the worker; second, the patients vary in the degree of reliance they have in the word of the social worker at admission that she will be seeing them on the wards; and third, most of the lobotomy patients, because of their medical condition were unable to take the initiative. In one fifth of the cases it was impossible to distinguish who took the initiative, patient or worker, but instead the contact was considered cooperative and mutual. Along with these ten cases, there were four cases where the worker originated the initiative, the responsibility for later interviews assumed by the patient. The remaining five cases were those where the patient definitely took the initiative in calling for the social worker. Several of these contacts involved getting in touch with relatives, answering questions about treatment or hospital routine, or in regard to clothes the patient wanted or needed. These five cases, though a small proportion of the fifty studied, are important the writer feels in the light of the following quotation:

> The patient cannot come to the social worker to show that he is ready to do something about his predicament--the doors are locked. She then has to go to him, thus creating a situation, the correct handling of which taxes all her knowledge of human dynamics and of client-worker relationships. She even has to start the conversation to explain who she is.[5]

No longer can this be held completely true. The presence of the social

---

5. Esther C. Cook, "How the Psychiatric Social Worker in a Psychopathic Hospital Uses Some of the 'Specifics' in her Agency to Aid in the Treatment of the Patient," Newsletter, 9:17-20.

worker at admission nullifies the "locked doors". The social worker is known. She can be contacted.

TABLE III

TYPES OF ACTIVITY ON PART OF SOCIAL WORKER WITH THE PATIENT

Type	Number of Cases
Friendly contact, reassurance and support	39
Future planning	18
Regarding staying on in the hospital and acceptance of hospitalization	7
Reassurance that conditions at home all right	6
Link with community and relatives	5
Reassurances for family of patient's condition	4
Personal relationships with relatives to be worked through	4
Work out home or community situation cooperatively	3
Clothes and hospital detail (questions raised by the patient)	3
Act as substitute for relatives	2
Obtaining alcoholics anonymous	2

The classification in Table III gives the leading purposes of relationships between patient and worker. Because of the lack of recording minor problems in many cases, some may have been omitted. The above statistics include not just one purpose for each case, because in some situations there was a dual purpose. Twelve cases were omitted from the tabulation because 1. there were no problems presented; 2. the patient was too ill; or 3. another worker was active. This table reveals the wide range of actually rendered service by the intake social worker. Not only does the worker bridge the gap for the patient between himself and his relatives or

the community (or both) but also runs the gamut of requests expressed by the patient from the point of admission until after discharge. In other words, she helps the patient where his needs lie.

> Mrs. W. was worried about her two little children. Her husband had deserted, and the children would be uncared for. At the beginning of her stay at the hospital the worker saw the patient twice a week to tell her of the temporary plans that were made to care for them by her and the relatives, and to give a periodic description of the worker's contact regarding the children.

Here the worker recognized that the patient could not give her attention and interest toward getting well, because her children would be constantly on her mind. Realizing this patient's right to know what was happening to the children despite her hospitalization, the worker frankly discussed the situation with her. It is found that many such areas of anxiety can arise when hospitalization occurs, and that "having started on a sound, frank tone, the patients . . . are helped to move step by step towards an acceptance of the reality of their situation."[6]

Discharge

The worker's contact with the patient does not stop when he is ready to leave the hospital. Often this is where the worker assumes even more activity, because the patient has to step from the hospital back into the community, and planning may be involved. Of the fifty cases studied the worker was inactive at point of discharge in twenty-six cases, and active in twenty-four. Tables IV and V show reasons for inactivity and the purpose of activity.

---

6. Henrietta DeWitt, "Hospitalization and the Mental Patient," Mental Hygiene, 31:273, April, 1947.

TABLE IV

REASONS FOR INACTIVITY ON PART OF WORKER AT POINT OF DISCHARGE

Reason	Number of Cases
Transfer to another hospital	13
Nothing needed at point of discharge	8
Handled by another worker	2
Patient died	1
Problem present, but patient left without seeking help	1
Patient still in hospital	1
Total	26

TABLE V

AREAS OF ACTIVITY ON PART OF WORKER AT POINT OF DISCHARGE

Area	Number of Cases
Plan convalescent home care	10
Preparation for returning home	7
Explain transfer to state hospital	2
Check to see if patient had room to which to return	1
Encourage patient to leave hospital and go out on his own	1
Plan regarding job and contacting patient's job and boss	1
Plan for supervision outside for patient leaving hospital before waiting period after shock treatment completed	1
Plan regarding public welfare aid upon patient's discharge	1
Total	24

Table V shows that the worker assisted all the patients in making a smooth exit from the hospital. For example, most of the cases transferred

to another hospital necessitated no activity on the part of the worker (usually because the patient was too sick). In two cases, the situation necessitated the worker's helping the patient to accept the need of transfer to a state hospital rather than discharge home as desired. So too, the patient who did not want to leave the hospital was referred to the social worker for help.

Preparation and planning for return to the community was initiated by the worker from six weeks to two days prior to discharge. In only one case did the worker plan with the patient about the future from the point of admission. Eleven cases required ten or more days preparation. These were lobotomy patients and planning started usually ten days postoperatively and continued until discharge. The physical condition of these patients for some time postoperatively often made it impossible for them to return home and assume its responsibilities. The need for someone to care for them, demanded an intermediate step--a convalescent home.

More revealing than the above statistics is the fact that of the twenty-four cases in which the worker assumed a role, the preparation for discharge in eighteen was a continuation of the case work relationship already established. In the remaining six cases, there was only brief contact regarding discharge in the setting of regular interviews. This gives the picture, then, that the worker had consistently followed through on these cases, and that work around discharge was part of the continued pattern, and not an area of function by itself.

That the worker was active through the entire hospitalization of only eighteen patients at first glance appears to be a small number, because it

is less than half. It must be remembered, however, that of the fifty admitted, twelve patients were inaccessible at admission. Thus the eighteen patients with whom the worker was active from admission until discharge are really half of the total number to be considered.

In summary of her contact with the patients studied, the worker felt she had had at least a fair relationship with thirty of the patients.

TABLE VI

DEGREE OF RELATIONSHIP OF THE WORKER WITH THE PATIENTS

Type	Number of Cases
Good	17
Fair	13
None	18
Case carried by another worker	2
Total	50

Of the group where a fair relationship was obtained, all but two were lobotomy patients. Worker felt that due to their mental condition, the patients were unable to achieve any stronger degree of relationship.

In only one case of the fifty was focus of hospitalization on social service treatment (rather than medical service), and even this case involved the relatives and doctor as well. This case and another where medical service was the focus of hospitalization are presented below.

---

7. By "fair" is meant that the patient is not completely able to be cooperative in the interviews and planning. This was achieved in the cases where there was a good relationship.

Miss X., age twenty-five, came to the Boston Psychopathic Hospital in June, 1947 for a lobotomy operation, and was placed on visit in her own home after five weeks. She returned to the hospital in September because she was abusive and excessive in appetite, making a poor adjustment. At her first admission, the worker had screened the case as usual, but had gone on vacation and someone else had taken over. Even before this second admission, the patient was referred by the doctor to social service for future planning. There seemed to be a need for the patient to be out of the family in a convalescent home, making use of her time in a closely supervised, protected, work-training placement. Thus the patient's stay of four days centered on finding the right placement and discussing it and work possibilities with her. The patient was admitted to the hospital mainly in order to be taken out of the home where her placement had become intolerable to her and to her family and be available to the worker for intensive planning.

The worker was present at admission and made out the face sheet, but no screening was necessary, because the family was known through previous contact and the doctor had outlined the difficulty at hand. The patient was seen each day by the worker and the relationship was on a cooperative basis. The worker was expected every day by the patient who was also anxious to work things through. Contacts were on a case work treatment basis, as plans for a convalescent home were worked out. Worker helped the patient to realize that she was not helping herself by being inactive just sitting at home, and enabled her to take the step of going to Cooperative Workrooms, as employment, and to live at the convalescent home.

The worker had two contacts with the doctor--one before admission, where the problem was referred to the worker, and one before discharge to get approval from him of the plans that were arranged. After referral, the doctor left the case with the social worker, until discharge, saying that the patient could be discharged at the discretion of the social worker, when plans had been worked through.

The relatives were seen three times in order that they could accept and understand the necessity of the plan advised by the doctor. They had pampered the patient too much since operation, and explanation of why this was not the right treatment for a lobotomy patient was essential. Their relationship with the worker, like that of the patient, was good, and they accepted the plan presented.

> The patient was sent to the convalescent home on visit, and follow-up has been maintained by the worker--going out to see the patient, talking with the convalescent home, and also with the relatives. At the present time, the case is to be referred by the worker to another member of the social service staff, for further contact.

In this case, future planning was the aim for all those concerned. The worker was active from admission until discharge, and in this time of discharge was actually left to her by the doctor. The worker says that this can often be the case, where discharge plans are involved. Nor was discharge the end of contact, intensive follow-up being needed. Knowledge of and contact with community resources was indicated and essential. The previous admission of the patient was particularly helpful in the amount of "screening" necessary and in the smooth continuation of contact through a past relationship.

> Mrs. B. was readmitted to the hospital for a four week hospitalization, because of being depressed. She had been in Boston Psychopathic Hospital five months previously at which time the worker had been active especially in terms of interpretation of hospitalization to the husband. The patient lived with her husband and eleven year old son in a five room apartment. Worker was present at admission, in order to get an interval picture of this woman's illness and home situation. The patient needed much help and was seen at least weekly by the worker. This was on the patient's initiative because she was worried about her son who had severe attacks of asthma, and was placed in a foster home by social service in a local hospital. Worker was able to give the patient reassurance and support in this area and call the local hospital worker once a week in order to get a report about the boy, and give it to the patient. This reassured the patient and set her more at ease within the hospital setting. Three days before the patient went home on visit, the worker discussed this with her and the advisability of leaving her son in the placement until after she had had her first check-up in the out-patient department. The worker also arranged that the local hospital worker come and talk to this mother about her son prior to her going home. The worker's relationship with the patient was a good one and the patient showed a real need of help.

In contrast to the patient's hospitalization, the married daughter was the one who came in contact with the worker, rather than the patient's husband. This daughter needed much reassurance and interpretation about hospitalization and mental illness. Hereditary influence and factors in mental disease as they might affect her own children worrked her considerably. Although she was not seen regularly during the patient's hospitalization because her home was out of state, worker was able to help her become more understanding and cooperative about her mother's condition, and give her support during this period. Worker saw the husband only twice--once in regard to the financial situation and the other time in relation to the discharge of the patient and the inadvisability of the patient's being home alone.

The worker took the initiative of going to the doctor and presenting the problems she had seen. The doctor accepted this and the worker's plan to continue to see the patient throughout hospitalization. At discharge the doctor discussed with the worker the inadvisability of the patient's remaining in the home alone.

Since the patient has returned home on visit, worker has continued to see her frequently--once a week--when she came to OPD for shock treatments. At present there is a question of the necessity of the patient's returning to the hospital. This would again involve placement of the son, and worker has discussed a possible plan with the interested worker at the other hospital.

In this case we have a readmission to the hospital which demanded new contacts both in relation to patient and relatives. Reassurance, support and interpretation were all necessary, and the worker was able to carry to the family the advice of the doctor about the patient. This patient would probably not have been as cooperative had the worker not kept in contact with the worker from the other hospital, and thus reported to the patient. Interagency cooperation and planning is obvious here. There is also evident the possibility of follow-up by the social worker through the OPD, a follow-up which enables the worker to be a support to the family if and when a relapse or crisis occurs. The patient's daughter reveals another source of anxiety to families of mental patients--the hereditary component.

The worker was the person with whom the daughter could talk about her own children, as well as her mother's condition.

The focus of this chapter has been on the worker's role with the patient, but it must be remembered that the relatives and doctor play an equally important role in the total picture. The details of these relationships will be given in Chapters IV and V.

> We see the patient . . . separating himself from the old social situation, and moving into a new one, which is the hospital itself; needing to deal with the social difficulties that separation and newness bring; needing to relate to the new as he uses it for health, and then needing to leave it to return to the more complex, less protected social situation of the family and community life, which in the interim has become new to him.[8]

---

8. Ruth Gartland, "The Psychiatric Social Worker in a Mental Hospital," Mental Hygiene, 31:289, April, 1947.

CHAPTER IV

THE ROLE OF THE SOCIAL WORKER WITH THE RELATIVES

Many times the mental hospital setting is as unknown to the relatives as it is to the patient, so they too are reacting to the newness of the environment into which they are putting a member of their family.

> As the patient is both a product and a part of the family, it is quite natural that the individual's illness, which necessitates admission to a mental hospital should affect the family in that the members of the family may experience emotional, social, and economic problems of adjustment.[1]

Contact at Admission

Unless through the waiting list the relatives have been seen briefly before admission by the intake social worker, her first contact with them, like that with the patient, is in the admitting office. At this time, the focus of all concerned is on the actual admission of the patient, but the worker's relationship with the relatives begins here. They may react favorably or unfavorably to the hospital's interest and understanding of the patient. When the patient is taken to the ward, the social worker's immediate attention turns to the relatives.

> . . . When the relative sees the patient taken by the nurses to the ward and he himself is ready to return home, it would be a strategic point for the social service department to enter the situation to relieve the immediate emotional stresses and at the same time to establish the kind of relationship that would prove most valuable in future contacts with the patient and his family.[2]

---

1. Irma Landquist, The Use of the Psychiatric History Interview, Boston University, 1947, p. 1.

2. Esther Goodale, "Intake Interviews with Relatives of Psychotic Patients," Smith College Studies, 15:15, September, 1944.

It is this that the worker is now able to accomplish with the relatives. Of those patients admitted in September coming under the service of the intake social worker, relatives of twenty-seven were seen at admission. Of the other twenty-three, two were never seen (in one, another agency was active, and in the other the patient had no family), and the twenty remaining were seen within ten days. This number who were not seen at the time of admission is high, but not when correlated with the number of lobotomy patients. This group is mainly transferred from other hospitals, with transfer agents, not relatives, accompanying them. Thus the relatives first visit the hospital after the move.

The purpose of this first interview is fourfold: 1. to explain the hospital, its routine, and general facts regarding treatment; 2. to obtain a picture of the patient in his home environment and as his relatives see the problem in relation to the social, not the psychiatric, history; 3. to evaluate any social problem which may be involved at the onset; and, 4. above all, to get to know the relatives.

Explaining the hospital, its routine and treatment involves two main parts: the administrative details involved in admission procedure, and the questions the relatives have about this new setting. At the time of the admission of the fifty cases studied, the worker made certain that the patient coming from the community for admission had a ten day observation paper required by law. The financial situation and the amount the family is to pay for the patient's hospitalization is discussed, and this was a routine function for all the fifty cases. Because a diagnostic study and treatment permission blank must be signed by the relatives before tests

and treatment start, the worker takes this into the interview with her, interpreting the need for it and obtaining the relative's signature. Although these areas have to be discussed as part of hospital administration, the worker states that she handles them as they may present themselves in the interview, and not as the most important aspects.

It has been accepted that the relatives may have confusion about the hospital and treatment the patient will receive, and although a pamphlet entitled "What You Should Know About Boston Psychopathic Hospital" is given to the relatives at this time, the worker aims to clarify anything that they may ask. She explains the observation receiving wards for the more acutely ill patients with their precautionary regulations, as well as the number of studies that may be necessary to determine the ultimate treatment for the patient. The worker feels that it is important to clarify that Boston Psychopathic Hospital keeps only the acute cases that are treatable over a period usually averaging two to three months. This is to alleviate future demands by the relatives for long time treatment at this hospital. These questions, the worker realizes, are tinged with anxiety, fear, and uncertainty, and although she explains that it is impossible for the relatives to see the doctor every day, she knows their need to depend on someone and describes the availability of herself and those in the Executive Office who will keep informed in order to help them. She explains her role in the hospital and in relation to the relatives' use of her, including where she can be found--at the entrance of the Executive Office. As in the case of the patients, this gives the relatives someone and someplace to which to turn. In several cases it was evident that social

service was completely new, even where there had been previously some hospitalization, and questions about this service figure in the first interview.

While the explanation of the hospital and procedure could be a routine matter, the worker varied this according to the number of questions presented by the relatives, the degree of anxiety the relatives felt, and their previous experience with hospitalization. For example, in thirty of the cases studied, the interpretation of the hospital was interrelated with questions on the part of the relatives regarding certain aspects about which they were confused, whereas previous hospitalization or practical problems which temporarily overshadowed questions about the hospital decreased the amount of interpretation that was given. It is not an impersonal interpretation on the part of the social worker, but rather a personal approach according to the relatives' needs.

In the twenty-two cases admitted to the hospital for a lobotomy operation, the worker was required to spend much time with the relatives. Most of them knew a little about what a lobotomy operation involved, although in occasional instances they had been told nothing. Definite questions in this area were immediately noticeable. The worker did not explain in detail the lobotomy operation, but suggested that the relatives discuss it with the doctor. However, often she gave the following explanation: that the patient is always studied by the doctors at Boston Psychopathic Hospital for a period of time prior to operation to determine whether they agree with the referring agent; that once the operation is decided upon, the relatives are notified; that the patient after operation,

often reveals certain features such as apathy, enuresis, lack of interest, and a certain childishness; that improvement can take place over a period of a year; and that the relatives are given a report ten days postoperatively regarding the type of future plans recommended for the patient (return to another hospital, intermediate step of convalescent home care, or return to own home). Relatives of the lobotomy patients need a great deal of explanation and time from the worker. They take their part in the readjustment of the patient very seriously, and attend group meetings regularly. In her first interview with these relatives, she suggested the advisability of waiting to contact her about future plans until after the operation, pending its outcome.

There are two elements here which should be noted. First of all, there is an element of sharing already present in this interview--sharing between the hospital and the relatives. It is the belief of case work that help is given on a cooperative basis, and here the relatives are joining with the hospital for the well-being of the patient. At the same time, in relation to the lobotomy patients, the worker is using a preventive mechanism here in order that (with the risks involved) the relatives will know the possible results that may occur. This is true to a lesser degree with other forms of treatment such as shock or insulin therapy.

It is equally important for the hospital to know the patient as the relatives see him, not in terms of his symptoms, but as a person and of the home situation from which he comes. "The hospital needs to have knowledge of the patient . . . because it knows that in many instances clinical study alone will not give a true view of the disorder; so closely

interwoven are social and emotional factors."[3] For this reason the social worker talks to the relatives with a keen ear for the situation from which this patient comes--not in terms of getting a complete detailed social history, but to learn the situation as it is today, how the relatives feel the patient reached this point, and what he is like. It is a social history that goes further in that it is the beginning of a relationship--of the worker's being active from admission onward if necessary, and is keyed to the future rather than the past. The hospital has turned to the relatives because:

> It also wants assistance in making the patient's stay in the hospital as free from outside worry as possible, so that he may settle down to an understanding of his own difficulties and attempt to do something about them.[4]

The worker obtains a picture of the home situation with and without the patient, to what the patient will return upon discharge, and also learns who are the interested relatives. However, the relatives per se often need help. A study made previously of the relatives of psychotic patients stated:

> . . . that the families of committed patients, despite their former strengths and stability, experience at the time a member becomes mentally ill, a real need for reorganization and readjustment of their lives. Not only do they have to cope with their misconceptions of mental illness, but also with the fears, anxieties and uncertainties that inevitably arise at the time of hospitalization.[5]

---

3. Esther C. Cook, "How the Psychiatric Social Worker in a Psychiatric Hospital Uses Some of the 'Specifics' in her Agency to Aid in the Treatment of the Patient," Newsletter, 9:19.

4. Ibid., p. 19.

5. Helen Darraugh, "The Role of Social Service with the Families of Mental Hospital Patients," Smith College Studies, 13:188, December, 1942.

At this point also it should be noted that the relatives in some instances needed help around the meaning of mental illness. It was especially marked in six cases. "Misconceptions of mental illness and a state mental hospital may cause the family further anxiety and wonder."[6] Perhaps the most important part of the entire intake interview might be said to be the emotional tones surrounding it. Of the fifty cases studied, twenty-six showed marked feelings of fear or anxiety--and needed much reassurance at this point. Of the other twenty-four, seventeen were more interested and accepting than fearful. This number is affected by the number of transfer hospitalizations. The remaining eight cases showed lack of cooperation, no problems, or the relatives were not seen.

Of primary importance for this paper is that there was in a majority of cases evident anxiety. The fear and anxiety was expressed in many ways. Many feared the hospital out of ignorance, or were upset about the possible outsomes of the lobotomy operation. Some were afraid of mental illness per se, its hereditary possibilities, the way it might (through the patient) affect their future.[7] Others showed some relief at having finally come to a decision about the patient, but worried regarding the outcome. These fear reactions go hand in hand with the following more or less practical problems: planning for the children in the home, financial insecurity, emotional elements in the relative's making it impossible for them to

---

6. Irma Landquist, The Use of the Psychiatric History Interview, Boston University, 1947, p. 2.

7. See page 39 (Case at end of Chapter III).

accept hospitalization, future planning or convalescent care evidenced as necessary because of no home to which the patient can return, employment, lack of cooperation on the part of the relatives, or refusal to sign commitment papers. This gives a fairly complete picture of what the relatives bring to the first interview with the worker.

What did the worker do at this point? In five cases the worker became immediately active. In three she made referrals to the relative's local Family Service, in one she helped to make temporary plans for the patient's children and in the fifth case, she worked through an arrangement whereby the semi-invalid wife of a patient would keep in constant touch with the hospital and social worker about her husband although she could not come in to visit. But the worker did more than this. She accomplished the aim set forth in the following quotation:

> . . . a good social worker, while taking the history, can do much to help the patient's family to accept his illness, to allay their fears, and anxieties about his care in the hospital and about whether or not they have done the wise thing in following out the physician's advice in relation to the patient's commitment.[8]

The relation of this intake procedure to the later relationship and contact the worker has with relatives will be revealed in the next section, but the following case is presented in toto, as a prevue of this relationship. More than this, however, this case reveals the contact of the worker at admission, what this admission interview revealed and to what it led throughout the patient's stay in the hospital:

---

8. _____, "The Function of the Psychiatric Social Worker in a Mental Hospital," Newsletter, 12:7, Summer, 1942.

The patient, a twenty-five year old male, came into the hospital from the waiting list under Section 79. The diagnosis of DP-Paranoid was given after a period of study. Commited during his stay, he remained for a period of five weeks, then being transferred to another state hospital. He had not been previously admitted and was referred to Boston Psychopathic Hospital by family doctor. At the time of admission, the patient was unemployed, and lived with his sisters and parents, who for a six weeks period had devoted themselves to help him in his illness. Routinely, the intake worker was present at admission, although she did not take the face sheet. Due to his psychotic condition, the patient was not accessible to any help or explanation from the social worker at that time, but the relatives were seen by her after the patient was taken to the observation ward, for the purpose of picking up any social problems, and getting a social history. At this time, worker found that the ordinary explanation of the hospital, its procedure and role of social service was not enough for these relatives who were anxious and upset about the patient's need of care in a mental hospital. Because of this, the worker used much reassurance, and planned with the relatives that they should see her regularly on a weekly basis. Worker gave interpretation of the observation ward especially at this point, and the financial situation was discussed, to determine the amount the relatives were able to pay.

These relatives were seen once a week on an interview basis during the patient's stay at which time, worker was able to give further interpretation, reassurance and reports regarding the patient. This plan was carried on on the initiative of the relatives, since they looked up the worker each week. Two other problems had to be handled by the social worker with this family during the course of treatment. First was the signing of commitment papers for the patient at the end of the ten day period set by Section 79. The relatives were loathe to do this, and the worker was able to help family accept the validity of such a move. At the end of the patient's stay, the worker also played a big role in helping the relatives understand the doctor's recommendation that the patient be transferred to another state hospital. This move was very difficult for the relatives to accept, and they turned to the worker for supportive help at this time, in order to enable themselves to make this decision.

This family attended three group meetings during the patient's five week hospitalization, but were not active and it is questionable whether the worker was able to be of much help to them in this group setting. Despite this the social worker saw her role with the relatives as that of reassurance, interpretation and support.

> On the other hand, while the worker was able to help the relatives, the patient was too sick and she saw him only on a friendly basis. There was no need for her to be active around discharge with the patient because there was no question of the patient's need of a mental hospital.
>
> The worker contacted the doctor soon after admission to see what the psychiatric picture was, since she planned, with the doctor's approval, to see the relatives every week. She explained to the doctor what she had found in the areas of social problems, and the doctor accepted her function in the case. Worker had three conferences with the doctor during the patient's stay, with the doctor making demands upon the worker in no way except that of interpreting the need of transfer to the relatives. Worker considered her role with the relatives an active one, although she had relatively little contact with the patient. Because of the transfer to another state hospital, there has been no follow-up by the worker.

The intake social worker was active in this case from the time she entered the patient's name on the waiting list until plans were made for him to go to another hospital. After admission her activity could be described as being the determination of the kind of service needed, work with the relatives, and consultation and planning with the doctor. She takes the entire initiative at the beginning, and although this initiative is maintained with the doctor throughout the case, it is taken over by the relatives in their seeking out of the worker for interviews and reports on the patient's progress. Her role with the relatives was an active one, based on weekly interviews in a case work role. Her first interview included explanation, reassurance, and interpretation, all of which continued throughout her contact with them. She determined the presence of a social problem in the anxiety and fear of the relatives, and planned her help with this in mind. Her role with them was as a link between themselves and the patient, and their understanding of the illness. The worker met

particular problems as they arose (i.e. commitment papers and transfer to a mental hospital elsewhere), and was well acquainted with the family attitudes before these problems presented themselves. For the doctor, the worker was the informant of the social, environmental picture of the patient, carrying information to him, rather than his coming to her. She immediately picked up the doctor's demand for interpretation to the family of recommendation of transfer. The marked thing here is the smooth pattern maintained from admission to discharge.

Continued Contact

The worker's role with the relatives does not end with the first interview. In thirty-one of the fifty cases the worker had continued contact with them throughout the patient's stay. Most of these were on a weekly basis except in eight cases where, because of the nature of the difficulty, they were, at the beginning, much more frequent. In addition, as with the patients, brief contacts play a very important role. Partly responsible for this is the accessibility of the worker's desk, just off the reception hall, where she is in easy view of the relatives as they come and go. This was felt to be of prime importance because the worker is often available, a few moments at a time, and is thus able to answer many questions rapidly and briefly. In five cases, these brief conversations constituted the only contact between worker and relatives other than the formal interviews at admission and discharge. The telephone also is a source of brief supplementary contacts, but in four cases it had to be the main source of reports and help from the hospital to the relatives because of the distance of the hospital from the patient's home.

The very availability of the social worker to the relatives, assumes greater importance when it is realized that thirty of the relatives took the initiative to see the worker (after the first interview), whether it be for regular treatment interviews or for brief conversations. This reveals also the need the relatives have of a place to go to get information, reports, and above all of someone to whom to tell their reactions to being with the mentally ill patient. Of the remaining twelve cases in which the relatives did not completely take the initiative, the worker assumed initiative throughout in six, and in the other six, the initiative was mutual. It might be well to say that in many instances, the social worker saw several members of the same family at one time or another during the patient's hospitalization.

Purpose of Continued Contact

The giving of reports regarding the condition of the patient and the recommendations of the doctors for treatment; assistance in helping the relative understand the lobotomy patient; future planning in his own home or in a convalescent home; and interpretation of the need of transfer to another hospital constitute the main areas of function of the social worker in continued contact. Services to the relatives, in addition to these, were in each case unique. These are listed in Table VII.

TABLE VII

THE UNIQUE PURPOSES OF FURTHER CONTACT WITH THE RELATIVES

Purpose	Number of Cases
Help to make the relatives more cooperative in the hospital setting	1
Work through signing of commitment papers	1
Clarify regarding type of treatment patient is receiving	1
Give regular reports to a relative unable to come to visit	1
Financial needs and insecurity	1
Help with children of patient regarding placement	1
Help around relationship of wife to patient's mother	1
Help regarding anxiety of patient's young children about their mother	1
Help mother in handling her husband (the patient)	1
Decrease relatives' over-solicitousness for the sake of the patient	1
Relieve guilt and tension around patient's illness	1
Relieve hostility toward state hospitals	1
Keep husband of patient informed of a patient's progress	1
Help mother to be better able to handle her daughter	1
Temper attitudes of relative toward the patient	1
Total	15

The first three items in Table VII are areas directly connected with the hospital setting, into which the worker tries to help the relatives fit themselves. The next three are areas where environmental manipulation was necessary and the community was more directly involved. (In five cases the worker was working directly with other agencies regarding plans for both relatives and patients. This does not include the group which

necessitated convalescent home contacts). The remaining nine areas of contact were directly concerned with the relatives own emotional involvment in the situation. Slower movement, more subjective help and support were necessary, and the end result or accomplishment was in most of the cases superficial insight.

In all but six cases, the worker accomplished these purposes. The accomplishment was especially clear in the cases regarding future planning, because a patient would not be discharged from the hospital until adequate plans were made.

How did the relatives use the social worker? In general, it was obvious that she was someone on whom they could depend, someone from whom they could get help with their own emotional difficulties, or who could reassure them, giving them answers to their questions especially about the patient, since the doctor couldn't be seen frequently. The impression achieved is that the social worker is used in whatever manner the relatives feel they need her. She is the link between themselves and the patient, the doctor, and the agencies in the community. If she cannot help, she will refer them elsewhere. Relatives showed, in their use of the social worker,

> . . . fear of hospitals in general, fear of mental hospitals, fear that the patient would be mistreated, guilt that they themselves might be accused of avoiding their responsibility for care of the patient, shame that a member of their family must come to a mental hospital, fear and guilt that they may have been in one or many ways responsible for the breakdown, and fear that the same thing may happen to them or their offspring.[9]

---

9. Esther Goodale, "Intake Interviews with Relatives of Psychotic Patients," Smith College Studies, 15:16, September, 1944.

It was around these things that the worker was able to help. Below is an interview which demonstrates some of these reactions:

> The informant was the fiancee of a twenty-five year old male who entered the hospital and was given a diagnosis of Dementia Praecox, paranoid type. He had been delusional upon entrance to the hospital. Miss T. came to the worker to ask about the patient. She had found him quite upset because so far he had had no treatment and wondered why. He wanted to talk to the doctor. The worker explained that the patient was to have insulin therapy but had had to wait because of the lack of a bed in the insulin ward. However, she realized why her fiance had wondered and would ask the doctor to talk to him. Miss T. then asked about insulin therapy, how it was given and its difference from electric shock treatments, all of which the worker explained briefly. She was especially interested in what it does.
>
> Miss T. was obviously upset and told of how she had broken off with the patient some time ago. Then recently they went back together again. However, he had to come to the hospital. She said she could not help but wonder how much her leaving him might have precipitated the difficulty. Also, she wanted the worker to know that his brother too had been in a mental hospital. Was it due to the same thing and was it hereditary? Worker spent several minutes explaining that there are a multiplicity of situations and experiences that lead to a mental illness. Worker also emphasized the variability of opinion regarding the hereditary quality of mental illness.
>
> The observation ward also disturbed Miss T. because her fiance had been put back there from the convalescent ward, and she wondered why. Worker explained that the patient had become upset and had been unable to eat, so was put back into the observation ward where there are not so many demands made upon him. Worker went on to say that often patients have difficulty in situations where there is much activity in which they have to compete to a certain degree. The convalescent ward was more than he could handle in his present mental state.
>
> Miss T. accepted all this at its face value. The worker, realizing that Miss T. needed some help around her own feelings about her fiance's illness, suggested that she feel free to come to talk to the worker at any time. Worker felt that Miss T. should take the initiative and have some realization of her need of help, and not have help forced upon her.

Here is an interview where the worker was able to give a relative (fiancee) some objective answers to troubling questions. Not only were these things

troubling Miss T. but some were upsetting the patient, and the worker was able to adjust the situation between the hospital, doctor, relative and patient, and could report to the doctor that the patient needed to talk to him. The worker realized Miss T's need for future reassurance. She did not force her help upon her, but tried to make her feel it was there if she wanted it.

Group Meetings with Relatives

The social worker holds group meetings one day a week after visiting hours. To these meetings all relatives and friends are welcome. It is an attempt to help them learn all they can about mental illness and the hospital by sharing questions and experiences within the group situation. Of the cases studied, relatives of twenty-four patients attended at least one group, and the majority attended all while the patient was hospitalized. The worker felt that nineteen were definitely helped. What was accomplished with the remaining five it is difficult to measure. The broad general achievements were greater acceptance and understanding of a hospital for mental illness and its aims, clarification of the general picture of mental illness, the understanding of the various types of treatment given to the patients and the effects produced, and in two cases mutual reassurance between relatives of the various patients. The latter is probably much more of an accomplishment than can be measured due to its immeasurable quality.

The relatives themselves choose the main subject to be discussed at the meetings, and doctors come periodically to discuss various factors concerning mental illness and types of treatment. It is not imperative that the discussion stay on the one chosen subject alone. Questions of any kind

encouraged, with the exception of the individual characteristics of a certain patient's illness or difficulty in the hospital. The worker suggests the particular relative discuss these with the worker or doctor separately. This enables the group to spend the time together on subjects of general interest.

At the meeting to be described here, seventeen relatives were present, a relatively characteristic number. The focus of the day was upon "The Role of the Relatives When the Patient Returns Home." A visitor to the meeting (not a relative) opened the discussion asking about the hospital. The worker answered with an historical approach, explaining how the focus had changed over the years since its establishment.

Following this, questions flowed freely. One relative asked whether every religious faith was represented on the medical staff, since the patient with religious delusion might feel that a doctor of a different faith did not understand. Worker answered in the affirmative, but emphasized that the religious conflict may be only a symptom. Further discussions centered around the type and meaning of commitment, the types and effects of treatment and the relatives' responsibility to the patient both in and out of the hospital. General effects of insulin and electric shock treatment as described by a visiting doctor the previous week were explained; why the patient under treatment is controlled, when he can and cannot go home, and the importance of the physical examination prior to treatment and the reason for it. Other relatives were asked to contribute to the discussion about the reactions of their patients to shock treatment, and they gave a picture of their hazy memory, but otherwise general

improvement. Worker emphasized that the patients' loss of memory reflects their inability to remember what happened during treatment. The relatives were active in giving vent to their feelings and impressions, and affect was quite apparent.

Some time was spent by the worker in discussing the various types of commitment and the legal procedures surrounding them, and because of these and other questions by the relatives, it was not until the latter part of the meeting that specific questions relative to the topic of the day were asked. One relative was interested in whether it was permissible for the patient to talk about his illness when he came home. The worker explained that the patient is apt to become aware of the attitudes of the relatives toward his illness and if they appear disturbed about it by attempting to divert him, he may become upset too. Talking will do him no harm. Another relative asked whether to allow the patient, when he returns home, to go out on a date. Worker emphasized the importance of the use of good common sense on the part of the relatives in any of these situations.

Throughout the discussion the worker was very relaxed and willing to answer any of the questions that the relatives might have, and her acceptance and understanding gave a certain freedom to the meeting. She took advantage of any opportunity made available by their questions to give reassurance and to reemphasize important points, such as, the inadvisability of the relatives taking the word of the committed patient because he is not always reliable; the necessity of the relatives' deciding what is best for the patient; and the desire of the hospital to set their minds at ease regarding the hospital setting in which they have placed a member of their

family (the wards are open for the relatives to visit). This setting is different from the worker's usual role with the relatives. Here her work is on a group basis, and involves general questions not as personally motivated and charged in respect to a particular patient. The meetings serve an educational function, but more than this is involved. The similar emotional stresses and problems that these relatives reveal, find a common meeting ground in this setting, and in many instances one relative helps another without the worker's being involved. A certain emotional catharsis results.

From the three main areas of function of the intake worker with the relatives (intake, continued contact, and group meetings), one characteristic is obvious; repetitions frequently have to be made. "Sometimes even a careful explanation seems to go right over the relatives' heads, not because they are unintelligent, but because they are preoccupied."[10]

As a practical conclusion of this discussion of the worker's role with the relatives, the following case is presented.

> Mr. O., a twenty-eight year old male, came to Boston Psychopathic Hospital from another hospital for the purpose of having a lobotomy operation. He was hospitalized at Boston Psychopathic Hospital under Section 51 RC for a month and a half and the worker picked up the case at admission. She was present when the doctor admitted the patient, and explained that she would be seeing him on the ward. The worker maintained a friendly contact with him throughout his hospitalization, but he was too ill for any further help from social service at that time. He was on the danger list postoperatively because of pneumonia and it was the worker who took the initiative in her six or seven contacts with him on the ward.

---

10. Edith Stern, Mental Illness: A Guide for the Family, p. 1.

Worker's main attention in this case was with the mother of the patient who from admission seemed extremely emotionally tied up in her son's illness and needed much help. Because the mother came to the hospital with her son in the ambulance when the transfer to this hospital was made, the worker was able to see the mother immediately after the patient's admission. The purpose was to ascertain the financial situation, to locate any problem that might present itself, and to explore the home for possible return of the patient to the community. Mother asked for much explanation regarding the lobotomy operation. The procedure of the hospital was also presented at this time.

The worker was able immediately to sense the guilt and tension this mother felt around her son's illness, and understanding of this mother's feelings was expressed by the worker at this time. She was obviously over-protective and concerned, and the worker arranged to see her regularly on a bi-weekly basis for interview throughout the period of her son's hospitalization. After the first interview with the mother, she took over the responsibility of her contacts with the worker because she needed and wanted help. Worker had ten interviews with this mother around her own emotional involvement with the patient, and also around the problem of future planning. The mother was exceedingly reluctant to allow the boy to be returned to the state hospital, and this had to be worked through. Worker was able, through supportive treatment, to relieve much of the tension and guilt of this woman so that she was better able to accept his rejection of her which was so painful. The mother was able to come to the point of asking for advice around the treatment of her son. For example, she asked if, when her son went home, she had trouble with him, would the hospital and social service help. However, the mother's viewpoint toward the previous state hospital was not altered, but the patient was able to go home, thus making it unnecessary for the mother to face hospitalization again for him. The worker aided also in the area of future planning, and through the worker, the mother was able to vent her hostility toward the other state hospital which had not made social service available to her. The mother attended six group meetings which served as a further vent for her hostility around mental illness and mental hospitals and through her active role in these meetings, the worker was able to be of further help.

The worker took the initiative in contacting the doctor about the case, soon after admission, and immediately the doctor asked what the worker knew about the case. Worker explained the mother's feelings and the home situation, getting the doctor's opinion and approval to continue work with the mother. Worker also tried to get a picture of the probable results of lobotomy with this patient and contacted the doctor again later about this. Worker's and doctor's contacts were mutual and participatory in regard to this case.

> In the last conference with the doctor, there was a joint discussion on the advisability of the patient's returning home. At this time, the doctor referred the discharge to the worker, saying that the patient could return home if the home was satisfactory, leaving this to the social worker for evaluation.
>
> For one month and a half after the patient returned home on visit, the worker did follow-up work with this patient and relative, largely however, on the initiative of the relative who would call for advice. Worker had two interviews with the mother, and numerous telephone calls regarding questions by the mother of how she should handle the patient. At the end of this period, the patient was referred to another social worker because of the dynamics involved, while the original worker continued with the mother.

In this case the worker was active with the relatives and doctor, but maintained only a friendly contact with the patient. The worker's main area of service was with the mother, who not only demanded the usual help around lobotomy operation, but case work treatment of her own guilt and tension about the son. A twice a week plan was carried on under the initiative of the relative, and so likewise, her contact became a cooperative project. The worker's role with the relatives was threefold: future planning, present understanding of hospitalization and hospital procedure, and treatment of the mother's own feelings around the son's illness. The relatives saw her role as a supportive one and for planning, as well as a new experience since the previous state hospital had given little help. Her role was a comparative one for this mother in relationship to her previous experience.

CHAPTER V

WORKER'S ROLE WITH THE DOCTORS AND IN FOLLOW-UP

In this study, the function of the social worker with the doctors, and in follow-up was technically separated from the material of her role with the patient and relatives. This separation was in order to better show individual characteristics of these areas of function. Any distinction of this type is artificial, because the worker's services to the doctor, patient, relative, or in follow-up are of necessity interrelated.

Doctor and Social Worker

The position of "Intake Social Worker" was created two years ago in the hopes of further integrating the services (especially the medical) of the hospital in behalf of the patient. How has this been done? First, she has attempted to be of help to the doctor in understanding the patient in his social setting; second, she has paralleled her handling of social problems with medical treatment throughout the patient's hospitalization; and third, the social worker has accepted Executive Duties involving responsibilities which free more of the doctor's time for medical service.

One of the duties she has accepted has been the responsibility of the waiting list, whereby she contacts patients to enter the hospital for treatment as soon as the doctors can assume a new case and a bed is available. Her presence at admission and periodically making out the face sheet shares a responsibility once completely the doctor's, and her knowledge of the patient throughout hospitalization has enabled her to answer questions of the relatives that would have otherwise demanded the attention of the doctor. In this respect, she has a selective function in the amount and

type of questions which will take up the doctor's time. Because of her continuous contact with either patient or relatives, the worker obtains first hand knowledge of the social situation and problems involved, which she relates to the doctor for his use in better understanding the patient. For example, the discharge of the patient by the doctor may be affected by the worker's knowledge of the home situation. The worker states that the doctors do not mind, in fact are glad to have her talk with the patient, but before she assumes an active part in the case, she discusses it with the doctor. Thus, the worker's paralleling her help for the patient or relatives with that of the medical service pends the acceptance of the doctor of this role. This involves a contact with the doctor soon after admission. In the fifty cases studied, the doctor and worker had a conference within a few days after admission in regard to twenty-seven of these cases. In the remaining twenty-three where there was no such contact a conference was held in nine of the cases ten days postoperatively. This is because future plans stand pending the result of the operation on very ill lobotomy patients. Unless the worker needed to point out immediate problems or her desire to work with the family from the beginning, a conference was not essential until postoperatively. In five of the cases, no conference was held until discharge at which time the patient's condition and future plans were discussed. Six of the cases demanded no work between doctor and social worker, five because the patient was too ill or died or was transferred to another hospital, and one because there were no social problems. In three cases there was no conference immediately following admission because there had been planning between the social worker and

doctor regarding the situation prior to the admission of the patient from the out-patient department.

In twenty-nine of the forty-four cases where the doctor and worker were both active, the worker took the initiative in contacting the doctor about the case, and the doctor came to the worker in the remaining fifteen. The worker took the initiative in twice as many cases as the doctor. This is interesting in the light of the past role of the psychiatric social worker in a mental hospital, where the doctor usually came to the worker with problems he found revealed in working with the patient. Interpretation to the new young doctors who have had no experience with social service often needs to be more detailed, and the worker considers it a part of her function to help them see the use of social service in specific situations.

In each case regardless of whether the doctor or worker took the initiative, the discussion centered on the situation both socially and medically, as it stood at that time. Joint discussion was the idea of the conference. The doctor did not come to the worker to report what the medical situation presented unless there was a social problem involved. However, in several instances the worker went to the doctor to describe the social situation per se. This is understandable in relation to the original definition of the social worker's purpose in reviewing each case--"to be of help to the doctor in understanding the patient."

Where the doctor came to the worker in regard to specific cases, four involved conferences postoperatively about referral to social service for discharge and convalescent plans. Relatives of two patients were referred

to social service for medical interpretation and reassurance. In one of these cases the relatives were over-anxious and solicitous about the patient's condition, while in the other, no lobotomy operation could be performed and needed explanation. Four cases had specific need of social service assistance and the doctor said so. In two of these four, the relatives were in need of case work service around their relationship with the hospitalized patient. In the third case, the father of the patient expressed concern about his son's job and the reaction of the employer to mental illness. The patient in the fourth case, showed anxiety about his family's knowing about the hospitalization. In the remaining five cases, the doctor had seen no specific, immediate demand for social service, but contacted the worker about the social situation to complete his picture of the patient. In three of them a need of social service to be active was found.

While the worker took the initiative in majority of these cases, the doctor had further demands to make during the hospitalization of twenty cases. This can be explained because it became apparent as the study progressed that often the worker and the doctor would be trying to locate each other at the same time to discuss the same patient. This can be called "mutual initiative", and was obvious in sixteen cases. This condition made it impossible to determine the initiator in more than an approximate way. Further than this, in many cases the doctor had no need to refer to social service until discharge, and in fifteen cases he had no demands at all throughout hospitalization.

The predominance of referrals by the doctor to social service at some time during hospitalization were for future planning (discharge and convalescent home care), although referrals sometimes included such things as: case work with the relatives, interpretation of medical findings or treatment, help with the relatives' acceptance of the hospital routine and becoming cooperative, and as contact between patient and relative.

Table VIII gives reasons for the worker's taking the initiative in contacting the doctor, outside of the purposes of supplementing the information of the doctor, and getting his permission to pursue her activity. It must be remembered that often these purposes overlap. For example, while the primary purpose may be to discuss discharge and future planning, she may at the same time be obtaining information for the relatives.

TABLE VIII

REASONS FOR WORKER'S CONTACT WITH THE DOCTOR REGARDING PATIENT

Reason	Number of Cases
To determine medical situation	8
Discharge and future planning	8
Reveal to doctor the need for social case work in the situation	8
Information for relatives	3
Advice regarding what to do in a particular situation	1
Regarding sending a medical student for a social history	1
Total	29

As in the case with the patient and relatives, all the worker's contacts with the doctor are not formal conferences. Many are only brief conversations to obtain the answer to a single question. Such contacts are

not recorded and it is therefore impossible to list statistically the number of times the worker discusses a case with the doctor. The scheduled conferences however, fall into three groups: to get information for the relatives, or for the worker herself; to discuss the cooperative efforts between the doctor and worker in one case where both are active; and to get approval of plans made by the social worker (generally about discharge). The number of conferences varied according to the length of the patient's stay, but it the majority of instances were weekly or bi-weekly. The exceptions were cases which demanded only a conference right after admission or prior to discharge; or cases where because the worker was seeing the relatives on an intensive basis, continued, frequent conferences were essential.

The number of continued mutual contacts between worker and doctor throughout these cases, reveals the degree to which the two professions go hand in hand, step by step, in their treatment of the patient throughout his hospitalization. This is carried still further in the worker's cooperation with the doctor at discharge. She attends discharge meetings held bi-weekly by the doctors and here can voice her opinion regarding the social situation to which the patient will return. In this way she explores every discharge to determine whether the home environment will be damaging to the patient's condition. In twenty cases the doctor referred the case to the worker stating that the patient could go home whenever plans had been made. This, it seems, could be based on the fact that "it is expected that during the patient's stay in the hospital the social worker will have sufficient contact with most of the patient's relatives to

know the general situation in the home."[1] In some instances, the doctor stated definitely what the arrangements must be. For example, he stated in six cases that the patient must not return to a home where she would be alone, while in ten cases the worker was requested to make convalescent home plans. Only four cases necessitated social service at discharge where she had not previously been active, and in nine cases no referral was made by the doctor because the worker was continuing a case work relationship of which the doctor was aware. Seventeen of the fifty cases required no help from social service at discharge.

> Mrs. K., age thirty, was at Boston Psychopathic Hospital for a period of one month, where it was determined that she had a reactive depression. The worker saw the patient for the first time when her name was placed on the waiting list prior to admission. Mrs. K. was referred from the out-patient department, and the doctor discussed the case with the worker before the patient was admitted. He felt that it was as much a social problem as a psychiatric one. The worker was present at admission, making out the face sheet and getting to know the patient. The worker saw Mrs. K. regularly, twice a week, on a mutually cooperative basis. Mrs. K. was an English war bride who was very upset over marital difficulties with her husband who was alcoholic. There was no money or adequate housing. Mrs. K. wanted to get a job and become independent. A great deal was accomplished by the worker in being able to put the patient at ease, discuss job possibilities, and let her talk out her thinking around whether to separate from her husband. The worker assumed a supportive role, and her relationship with the patient was good.
>
> The husband was not seen except once when he had been visiting his wife on the ward. Another agency was interested in this family and the worker maintained a contact with them in order to obtain information and also to give reports. Despite the preadmission conference, the worker and doctor discussed the case soon after the patient was admitted to determine what approach should be made. It was agreed that the worker should assume a supportive role to help the patient become relaxed and work through plans for the future. Conferences were held by the worker and doctor on a weekly basis, and

---

1. Hester Crutcher, A Guide for Developing Psychiatric Social Work in State Hospitals, p. 29.

when the doctor on the case was changed, the worker discussed the case and its preceding accomplishments with his successor. Their initiative was mutual and the case was presented jointly at staff meeting. Each contributed their knowledge of the case over a period of treatment. Summarizing hospital treatment, the doctor dealt with the ill part of the patient, while the social worker's focus was more on the well part.

When Mrs. K's husband convinced her to leave the hospital and accompany him to his family's home in another part of the state, the doctor and worker discussed the advantages and disadvantages involved in such a plan. They could not prevent her from leaving the hospital since she was a voluntary patient, but the worker did suggest to Mrs. K. the name of an agency she could contact in the future for help if it were needed.

The worker's contact with doctors in the out-patient department in regard to admission of patients into the hospital, and the use of a social worker in helping to make the transition into the hospital are shown here. The doctor took the initiative in the referral of the case. After that, there was a cooperative treatment situation and the presentation of this case at staff meeting reveals the responsibility held by the worker as well as the doctor.

The worker and doctor started together with this case even before admission of the patient, since the doctor, when he had seen the patient in the OPD, had realized her need for social service. Both doctor and worker, however, defined together the worker's role as that of helping the patient become more cooperative and of working through the patient's various reality problems.

This case emphasizes the interrelationship of any social work help with the areas of service around it--not only inside of the hospital, but also with regard to other agencies. "A social service department cannot

function independently, and as a separate entity. It must relate itself to the hospital in its entirety."[2]

Follow-up

That the discharge of the patient from the hospital can be a threatening experience for both the patient and the relatives is a well-accepted fact. The patient may fear to find the community changed, himself unable to cope with the demands to be made on him, or the stigma attached to his having been in a mental hospital more than he can handle. So too the relatives may worry over the care of the patient or the way he will fit into the home routine. This is especially true of the lobotomy patients. The period following hospitalization has for a long time been considered "as a convalescent period during which the patient's condition is evaluated by the way in which he is able to adjust in the community and handle his problems in personal relationships."[3]

Of the cases represented in this study, the worker maintained no contact with twenty-seven of the cases following discharge, and of this group it is interesting to note that referral to another agency was made in only one case. Table IX on the next page shows the reasons for no follow-up.

---

2. R. R. White, "The Social Services in the State Hospitals in Illinois," Mental Hygiene, 27:559, October, 1943.

3. Henrietta DeWitt, "Hospitalization and the Mental Patient," Mental Hygiene, 31:275, April, 1947.

TABLE IX

REASONS FOR NO FOLLOW-UP

Reason	Number of Cases
Transfer to another hospital	14
Voluntary discharge	5
Patient died	2
No problems	2
Refer to another agency	1
Patient left hospital against advice	1
Transferred to another worker	1
Still in hospital	1
Total	27

Of twenty-three cases where there was follow-up of some kind, the worker was more active in fifteen than in the other eight. The worker assumed the initiative in only nine of the cases, while the relatives contacted the worker in nine others. In five cases it was a mutual follow-up, neither having to be too active. Despite the fact that follow-up was initiated by the worker in only nine cases, it is interesting to note that contact was maintained with twenty-three. The relatives, it is seen, felt free to contact the worker after discharge as a result of her suggestion that they get in touch with her regarding any questions or problems that might arise. These contacts were made by telephone calls to the worker (four cases), post cards describing the patient's whereabouts and progress (three cases), or actual visits to the hospital to see the worker (two cases).

In all ten of the cases discharged for convalescent home care, the worker maintained a real follow-up role. This included actual visits to the convalescent home and the patients in four cases. These were lobotomy

patients who presented special nursing problems and the nursing homes often needed help in learning how to understand and handle these patients. In the other cases contact was maintained weekly with the nursing home by telephone. In one case contact had to be maintained by mail due to the distance from this hospital. Throughout the period of convalescence in nursing homes, the social worker talked with the family in seven of the cases. In one case, the patient was seen herself after an OPD check-up.

In four cases, a weekly interview arrangement was kept with the relatives in order to help them understand the patients and their adjustment to the community. In one case, a similar contact was maintained by frequent phone calls. In only two of the cases did the worker visit the relatives of patients in the home; rather, the relatives or patient came to the hospital to see the worker.

These contacts with the relatives and patient himself give a picture of "how he is meeting the community demands and whether he is improving, holding his own, or whether his illness seems to be recurring."[4]

The following case will show the relationship of follow-up to the rest of the worker's function in the hospital.

> Mrs. V., age fifty-seven, came to the Boston Psychopathic Hospital for a lobotomy operation, and remained for two months. The worker realized from the beginning that the patient would have no home to which to return pending recovery, and that this would necessitate future planning through placement. The patient was seen by the worker in weekly, friendly contacts postoperatively. Toward the end of her stay, the patient was able to take a cooperative part in regard to future plans. There was preparation for

---

4. Hester Crutcher, A Guide for Developing Psychiatric Social Work in State Hospitals, p. 34.

discharge in discussion of convalescent homes and the use of one as an intermediary step prior to her return to her own apartment. Because of the patient's condition, the initiative had to be on the part of the worker.

The worker talked with the relatives soon after the patient's admission and saw them regularly about eight times during the patient's two months stay. They needed orientation about the hospital and especially around the lobotomy operation, although they were completely cooperative throughout their contact with the hospital. Through the worker, they were able to better understand the condition and behavior of the lobotomized patient and be reassured regarding the patient's being on the danger list immediately postoperatively. They came to see the worker as their contact with the hospital and the patient, and were helpful and cooperative in planning around convalescent care.

The doctor took the initiative in contacting the worker two weeks postoperatively in regard to future plans for the patient. Up to this point there had been no conference, but the doctor had accepted the worker's role with the relatives. The worker was aware of this prior to referral and discussed convalescent homes with him, since she was already active on the case. The worker made plans for the patient at a convalescent home, obtained the approval of the doctor, and the patient was discharged on visit. Since discharge, the worker has continued to be active with follow-up of this patient over a two month period. She has visited the convalescent home and the patient; the relatives have been to talk with the worker; and, to supplement this, the worker has kept in touch with both the family and convalescent home by telephone calls.

Of particular interest in this case is the emphasis placed on future planning. Worker maintained only a moderate contact with the patient until discharge was imminent, and at this time convalescent plans were discussed in detail. Future planning, involved the patient, relatives, and the doctor, needing help and cooperation from all of them. It involved helping the patient to accept this intermediary step in the process of returning home, helping the relatives to assume an active, understanding role, and in getting the approval of the doctor in plans that were made. The problem in the case was recognized from intake by the worker and her approach

toward the patient throughout hospitalization was keyed to the necessity of this eventual planning.

Because of this type of problem, the worker maintained a contact in the manner of follow-up. This consisted of visits, interviews and telephone calls. One point is important in that the worker carried her role into the convalescent home, working with this home around the patient's needs.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Summary

The purpose of this study was to define and describe the role of the Intake Social Worker or the Supervisor of House Social Service at Boston Psychopathic Hospital. It was felt since the position had been in existence for only two years that such a study would be valuable through investigating a certain number of cases covered by the worker. The approach was toward studying what the worker herself felt she was doing as revealed by the cases studied and not what the patient, relatives or doctors felt she had as a function. The month of September, 1947 was chosen and fifty admissions came within the jurisdiction of the intake social worker during that month. The aim of the writer was to study the role of the worker in these cases in its relation to the doctor, patient, relatives and community. The form of the paper was consequently divided in this way. The distribution of diagnosis was heavily weighted by Dementia Praecox and of the group twenty-two were lobotomy patients. The latter grouping, the study revealed, provided particular areas of function for the worker.

The worker's role with the patient was immediately obvious. In all but four of the fifty cases, the worker was present at the admission of the patient, and these four were seen within two days. The worker's control of the waiting list for admission into the hospital gave her an opportunity sometimes to have contact with the patient or relatives prior to admission. Previous hospitalization helped in evaluation of the amount of interpretation that might be necessary at admission, and here continuity of procedure

was obvious due to previous experience both for relatives, patient and the worker.

The worker was verbally active in more than half of the cases by giving explanation, interpretation and reassurance to the patients. Non-verbalization or passivity on her part was not seen as lack of service, but rather as a security factor. Her presence alone could be as important to the patient as what she might say in the way of reassurance.

The case records revealed that many practical problems present themselves in the admitting office and the degree to which the worker was able to help and reassure around these difficulties was related to the decline of resistance to hospitalization.

In the worker's continued contact with the patients, it was apparent that brief friendly contacts are a part of the overall function of the social worker and a valuable factor in the service rendered. Along with this, there is a marked difference in degree of activity with various patients, according to their mental condition and need for social service. The lobotomy patients produced a characteristic pattern, in that little contact was made until postoperatively, at which time the worker became active. Of those patients seen regularly, the majority were on a weekly basis.

A wide range of actually rendered service by the social worker from admission onward, gave evidence that the worker helped the patient in the area where his needs lay and her service fitted the individual,--whether these needs be future planning, a link with relatives and community, or just a friend.

The worker's role with the patient was continued through discharge in order to achieve the easiest return to the community. This included interpretation regarding transfer to another hospital, encouragement to leave the hospital, or convalescent home planning. Here again the lobotomy patients revealed a consistent pattern, in that planning began ten days postoperatively in all. In other cases, it was initiated from two days to six weeks before discharge. In eighteen cases, the worker had continued contact with the patient from admission through discharge, which, relatively represented half of the total cases. The social worker had a fair relationship with more than half the patients and revealed use of psychiatric case work principles and techniques throughout these relationships. What can the psychiatric social worker do for the patient? It can be summarized in the following points:

1. She can help make the unknown social environment of the hospital, the known.

2. She can help him with what social difficulties he has--and deal with them in the protected environment to prepare him for the problems of the wider community again.

3. She can give him continuous support and acceptance of his sick and well self--non-judgmental, understanding attitudes, her knowledge of the obstacles in the way of his adjustment, (help him increase his self-awareness).

4. She can individualize him for the hospital and help him use the hospital's health program.[6]

With the relatives, the worker's service was in three areas:--at admission, in continued contact and in group meetings. Relatives of

---

6. Ruth Gartland, "The Psychiatric Social Worker in a Mental Hospital," Mental Hygiene, 31:289, April, 1947.

forty-seven of the patients were seen within ten days of the patient's admission (twenty-seven being seen when the patient was admitted) and the purposes of this first interview were: 1. to explain the hospital, its routine and treatment; 2. to obtain a picture of the patient in his home environment and as his relatives see the social problem; 3. to pick up any social problem which may be involved at the onset; and 4. above all, to get to know the relatives. In this interview, the worker began where the relative was, in terms of the present, not the past, making no particular subject the center of this interview. In thirty cases, there were definite questions regarding the hospital setting and in twenty-six cases emotional tones of fear and anxiety were present in the relatives. The worker handled these problems in one or all of three ways: 1. by alleviating as much as possible the anxiety and fear of the relatives by explanation, acceptance and reassurance about the situation, hospital and mental illness; 2. by helping immediately with the pressing practical problems; and 3. by recognizing difficulties that needed constant help during the patient's hospitalization and arranging a plan of regular contact with the relatives. Therefore from the start, the relatives find someone who knows the patient besides the doctor. As with the patient, the worker presents herself from the beginning as an understanding woman who is equipped and willing to help, and the relatives sense this.

In thirty-one of the fifty cases, the worker had continued contact with the relatives throughout the patient's hospitalization. Brief, unscheduled contacts of the worker with the relatives were found to play an important supplementary relation to the scheduled interviews. These short,

friendly conversations were made possible by the telephone and even more by the accessibility of the worker so near the reception hall. The worker's willingness to stop for a few minutes to answer a question or listen to a relative makes the relative turn freely to this worker for help. The relatives revealed a need to have someone to whom to go with their questions and feelings about the patient by actually taking the initiative in seeking the worker in a majority of the cases. Continued contact centered around four main areas: the giving of reports and reassurances, future planning, understanding regarding the need of transfer to another hospital, and interpretation of the lobotomy patient. Other services were more individually determined by the particular patient.

The social worker was used wherever she was needed by the relatives. They found her versatile and informed, ready to aid them or refer them to the proper source. This produced faith in the relatives. Throughout, the worker used the customary techniques of psychiatric case work, of explanation, interpretation, reassurance, support and environmental manipulation, and was the relatives' link with the hospital, patient and doctor.

By the group meetings, the worker fulfilled still another need of the relatives by bringing them together in a group situation wherein they could share with other relatives their experience with and knowledge of the hospital, mental illness and treatment. The worker played a passive role here when the relatives discussed their own opinions, and yet answered any questions as directly as possible, emphasizing points about which she felt the relatives should be aware. Questions more detailed than she felt equipped to answer, she referred to a doctor.

The main areas of contact for the worker with the doctor were to determine the medical situation, obtain reports for the relatives, to discuss discharge and future plans or cooperative efforts in a case where a case worker in the situation is needed or being used. To do this, it was necessary for her to know each case from admission in its social aspects as does the doctor in the medical. By seeing all the relatives of the patients, she obtained an understanding of the patient's home environment, the patient as the relatives see him, and the situation to which he would return upon leaving the hospital. This information she related to the doctor for his better understanding of the patient, and got his acceptance of her undertaking an active role in areas showing immediate need. Beyond this, the study showed that the doctor used the worker to protect himself and his time from interpretation to the relatives which need not necessarily come from the doctor, but which he felt the social worker could handle. Although the doctor probably saw the worker as an essential part of each patient's care from admission onward, it was definitely taken for granted that the worker was the link between hospitalization and discharge, because most of the referrals of the doctor to the social worker were for future planning. All but six of the cases the worker and doctor handled jointly, conferences being held according to the needs of the patient. Brief conversations were important, as were scheduled conferences for the cooperative work of both doctor and worker. In those cases where the worker assumed initiative, there was evidence that the doctor would have contacted social service at some time during hospitalization. When he did, it

was usually with a definite problem, but in several instances, these conferences were for the pooling of the knowledge of both.

Through discharge meetings, the worker played a role in the patient's leaving the hospital in expressing her opinions regarding the doctor's possible discharge of the patient. Discharge was a large area of function for the social worker in her planning with the patient, relatives and doctors. As in all other areas, case work techniques came into play. The worker revealed a realization of definite function in relation to the doctor. She assumed a role that saved him time in many areas, and yet a role which demanded cooperation between herself and the doctor. However, the doctor was the center of the team which was trying to help the patient and the worker recognized this, both in getting acceptance from him to work with the patient, and his approval of plans made by her.

Follow-up was indicated in twenty-three of the fifty cases studied and the worker was more active in fifteen than in the rest. The cases involving convalescent home care needed the greatest degree of service, but in all, this service was maintained through visits, interviews, brief conversations and telephone calls. The worker in only a few instances made visits into the community and relatively little of the responsibility for follow-up was done with the help of other agencies. In most instances, follow-up was a continuation of case work service during the patient's hospitalization. In general, the relatives felt free to contact the worker on their own initiative for guidance, advice, or reassurance about a difficult situation after the patient left the hospital.

Conclusions

1. The intake social worker, as revealed by this study, covered a great deal in each case. This leads the writer to the conclusion that many times these contacts were limited in time, which necessitated quick, accurate thinking and an excellent memory. The worker with the responsibility of this position, of necessity, had to know a great deal about legal procedure, treatment, hospital administration and procedure, and the community resources. All of these, plus the psychological knowledge of personality and its relation to the individual's environment, were essential for this psychiatric social worker.

2. The worker had a definite and large role to play with both the patient and relatives throughout the patient's hospitalization. There is a great need on the part of both for explanation, reassurance and interpretation throughout worker's aid with practical and emotional problems.

3. Since a worker is to be constantly available and of value to the patient and relatives, her presence at admission (and in a first interview with the relatives) is particularly essential. These two first contacts are diagnostically important in that many of the social problems that would eventually present themselves during hospitalization, are initiated here.

4. The mere presence of the social worker at admission, though she be silent, helps the patient feel more secure and accepted. The relatives also obtain this emotional tone.

5. In many instances, the brief unscheduled contacts play as important a role in the patient-worker, relative-worker, or doctor-worker relationships as the routine scheduled interviews.

6. There are indications that the knowledge of the existence and name of the intake worker gained by the patient at admission result in an increase in the freedom of the patient to request the help of social service.

7. It would appear that the intake social worker is as well known and accepted on the wards as the nurse and doctor.

8. The intake worker at Boston Psychopathic Hospital functions not alone on the level of intake, but in any area of service presenting itself throughout the patient's stay, or after discharge. If it is indicated, she functions in all, to a certain degree. In the light of this, the name of "Intake Social Worker" is not adequate to express the total area of her service.

9. Detailed past history of the patient is relatively unimportant to the intake social worker. It is her focus on the present needs of the patient that is all important. A situation where there is allowed free expression of questions and feelings on the part of the relatives elicits as much pertinent information as a history taking interview.

10. The worker's understanding and willingness to help on first contact with the relatives increases their freedom to come to her for help.

11. Accessibility (through physical location) is a determining factor in the number of brief, fruitful contacts between the worker and the relatives that occur.

12. The degree of activity on the part of the worker in taking initiative to point out problems to the doctor has greatly increased.

13. The doctor and workers have a definite need of service from each other in dealing with the patient and, realizing it, share the initiative

of usually discussing each case during the patient's hospitalization.

14. In follow-up by the worker, telephone conversations play the biggest part, both for the relatives and the social worker.

15. Follow-up is one of the lesser functions of the worker and a great deal of initiative is left to the relatives or patient, due mainly to the time limitations of the worker.

16. By the worker's assuming an active role from admission on, she is paralleling step by step social service with the doctor's medical treatment. In other words, treatment of social problems is carried out as medical treatment is going on.

The writer feels, in conclusion, that this study shows that there is real value in having a full time social worker functioning with house patients. The value of having her follow through with the patients and helping them with whatever problems arise from admission to discharge is clearly demonstrated.

Approved,

Richard K. Conant

Richard K. Conant
Dean

BIBLIOGRAPHY

Books

Briggs, L. V., History of the Boston Psychopathic Hospital. Boston: Wright and Potter Printing Co., 1922.

Committee on Psychiatric Social Work in Mental Hospitals, Essentials of Psychiatric Social Service Technique in Mental Hospitals and Mental Hygiene Clinics Attached to Mental Hospitals. New York: A. A. P. S. W., 1934.

Crutcher, Hester, A Guide for Developing Psychiatric Social Work in State Hospitals. New York: State Hospitals Press, 1933.

French, Lois, Psychiatric Social Work. New York: The Commonwealth Fund, 1940.

Richardson, Henry B., Patients Have Families. New York: The Commonwealth Fund, 1945.

Southard, E. E. and Mary C. Jarrett. The Kingdom of Evils. New York: MacMillan Co., 1922.

Stern, Edith M., Mental Illness: A Guide for the Family. New York: The Commonwealth Fund, 1942.

Zilboorg, Gregory, Mind, Medicine and Man. New York: Harcourt Brace and Company, 1943.

Unpublished Material

_____, Annual Reports of Boston Psychopathic Hospital, 1913-1946.

_____, Study of the Role of the Social Worker in a Mental Hospital. Compiled by the Group for the Advancement of Psychiatry.

Theses

Brown, Joan R., "The Need for Case Work with Relatives of Mental Hospital Patients." Smith College Studies, Volume XIII, No. 2, December, 1942.

Darraugh, Helen, "The Role of Social Service with the Families of Mental Hospital Patients." Smith College Studies, Volume XIII, No. 2, December, 1942.

Goodale, Esther, "Intake Interviews with Relatives of Psychotic Patients." Smith College Studies, Volume XV, No. 1, September, 1944.

Landquist, Irma M., "The Use of the Psychiatric History Interview." A Thesis. Boston University School of Social Work, 1947.

Ogilby, Anne P., "Environmental Factors and Mental Disturbances." A Thesis. Simmons College, September, 1946.

Periodical Literature

_____, "The Function of the Psychiatric Social Worker in a Mental Hospital," Newsletter, A. A. P. S. W., 12:3-11, Summer, 1942.

Cook, Esther, "How the Psychiatric Social Worker in a Psychopathic Hospital Uses Some of the 'Specifics' in her Agency to Aid in the Treatment of the Patient," Newsletter, A. A. P. S. W., Volume IX, No. 1.

DeWitt, Henrietta B., "Hospitalization and the Mental Patient," Mental Hygiene, 31:266-295, April, 1947.

Emery, E. Van Norman, "First Interviews as an Experiment in Human Relations," American Journal of Orthopsychiatry, 6:268-282, 1936.

Gartland, Ruth, "The Psychiatric Social Worker in a Mental Hospital," Mental Hygiene, 31:266-295, April, 1947.

Hamilton, S. W., "Life in Our Mental Hospitals--Its Meaning for the Individual," Mental Hygiene, 27:4-9, January, 1943.

Maeder, LeRoy M. A., "Generic Aspects of the Intake Interview," The Family, 23:14-23, March, 1942-February, 1943.

McCreery, Agnes, "Dynamic Possibilities for Psychiatric Social Work in Mental Hospitals," American Journal of Psychiatry, 99:137-139, July, 1942.

Muller, M. G., "Case Work Aid to Patient and Family Following Hospitalization for Mental Illness," The Family, 22:251-253, December, 1941.

White, R. R., "The Social Services in the State Hospitals of Illinois," Mental Hygiene, 27:554-573, October, 1943.

APPENDIX

APPENDIX A

SCHEDULE

Case No.

Name: Age: Date of Birth:

Problem: (Psychiatric)

Type of Admission: Commitment
Voluntary
Transfer

Date of Admission: Discharge: Duration of Stay:

Previous Admissions: Dates of Admission and Discharge:

Worker Active?

Remarks:

Source of Refer to BPH: Outpatient Doctor
Friend Waiting List
Other Hospital Other

Social Problems seen at Admission:

Patient: 1. Seen at Admission? Did Worker Admit?
Purpose:

If not seen at Admission, When?

2. Seen Regularly Afterwards?
How Often?
At Patient's Initiative?
On Worker's Initiative?
How Many Times?
Purpose?

What Accomplished?

3. Preparation for Discharge?
What did it Involve?

How long before Discharge?

Relatives: 1. Seen when Patient Admitted?
If not, When?

2. Purpose: Financial Situation:

3. Attitudes:

4. Seen Regularly During Patient's Stay?
On their Initiative? Worker's?

5. For What Purpose?

How Many Times?

6. Accomplishment?

7. Did Relatives Attend Group Meetings? How Often?
Active?
Was Worker Able to be of Help to Family Here?

8. Their Use of the Social Worker?

Doctors: 1. Conference to Clarify Problems soon after Point of Admission?

On Whose Initiative?
Purpose of this Conference?

2. Number of Conferences During Patient's Stay?

3. Doctor's Demands Regarding Case?

4. Initiative: Doctor to Worker?
Worker to Doctor?

Discharge: 1. Did Doctor Refer to Social Worker?
Reason for Refer?

If not, did Worker Assume Activity?
On What Basis?

2. Demands on Social Worker from:
   Patient:

   Relatives:

3. Active Role on Part of Social Worker?

Referral: 1. To Social Service Staff (Other than Intake Worker):

At What Point: Admission?
During Stay? When?
At Discharge?

2. At Discharge--Where?
Home to Relatives?
If not, Where?

To Out-Patient?
Other Agency? What One?
Any Follow-up? None?
Follow-up by Intake Worker?

Unofficial Contacts with Intake Worker after Patient's Discharge?

3. Rehospitalization:

Worker's Role?